ADAPTATION TO BEREAVEMENT OF WIDOWS WHO EXPERIENCED A SUDDEN LOSS OF A SPOUSE

By

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Individual interviews, emphasizing subjective experience of 51 widows who suddenly lost their spouses through war or military service, were analyzed regarding personality characteristics of self-esteem and internal-external locus of control as related to bereavement adaptations: (a) functioning at home and socially, (b) physical health status, (c) reported helpful and unhelpful experiences and (d) resolution of grief. The interview consisted of unstructured and structured parts. Resolution of grief and reported helpful and unhelpful experiences (intensity and type) were assessed by two trained raters.

No relationship was found between internal-external locus of control and bereavement adaptation dimensions. There was a relationship between self-esteem and bereavement adaptation.

The study emphasizes the importance of the interaction between self and others. The process of bereavement includes both the

internal dimensions of the widow's emotions and the external dimension of the widow's behavior. Factor analysis yielded 3 factors (accounting for 67.1% of the variance) delineating items involved in a positive outcome as well as difficulties during the bereavement adaptation process. Internal and external types of items involved were identified.

Results showed that high, in contrast to low, self-esteem widows generate and get more support. The former reported a higher level of satisfaction, while the latter group reported more health problems and more difficulties with new friends and finances. These differences were interpreted as expressions of emotion rather than objective difficulties since they are more compatible with the social support which was primarily practical-instrumental (financial help, baby sitting). Although all widows clearly needed support, low self-esteem widows, in contrast to high self-esteem widows, were not always able to obtain this support from others. Type of reported unhelpful experiences was the same for widows with high and low self-esteem. Widows perceived as unhelpful the advice "be strong" and "don't cry." Widows' grief work (normal intense and emotional reactions following a traumatic event), which tends to be avoided by the bereaved, is affected because the avoidance is socially reinforced. For grief (as a personal process) to be resolved, unconditional emotional support seems of utmost importance.

CHAPTER ONE
INTRODUCTION

The purpose of the research project is to study adaptation to bereavement among widows who experienced a sudden loss of a spouse and to determine to what extent certain personality characteristics affect adaptation to bereavement. Loss of a spouse as a result of death is considered as the most traumatic experience along the continuum of separation or loss. Sudden and unexpected death of a spouse (as in the case of war) is known to impose additional difficulty on the bereaved person (Epstein et al, 1975; Siggins, 1976; Lindemann, 1944; Silverman, 1975). Furthermore, Holmes and Rahe (1967) have shown, in research on their "social readjustment" scale, that out of forty-three life events, the loss of a spouse is the most stressful. Vachon (1976), in her investigation of bereavement and other severe stressors, reported that widowhood is extremely stressful compared with other life events. It is therefore not surprising that conjugal bereavement has attracted a great deal of attention among writers, notably Lindemann's (1944) pioneering work. The process of adaptation to the loss is referred to as bereavement, and grief is the emotional reaction to the loss.

Bereavement reactions are generally considered to occur in various stages following the loss. Bowlby (1961) described three phases occurring during the process of grief. The first phase is "numbness," which is characterized by reactions of disbelief and attempts to deny the reality. This phase takes place within a few hours to a few days after the loss. The second phase, characterized

by "yearning" and "protest," involves reluctant acceptance of the death, disorganization of the personality, sadness and loneliness. This second phase takes place from a few weeks to a year and longer. The third phase is one of acceptance and organization.

Schmale (1972) described the process of grieving as one which includes shock and disbelief followed by an attempt to overcome the awareness of the loss. The next step is characterized by an increase in memories of the relationship that the individual had with the lost person and fantasies about the future. The final step is the acceptance that the self can exist and survive without the lost spouse. But it is also during this step that the bereaved person is experiencing the reality of the loss. This reality may include possible unresolved grief reactions from earlier steps and inexperience in organizing both the self and new roles, as well as social and economic difficulties.

Many writers have attempted to measure bereavement outcomes using psychophysiological indicators such as rates of physical and mental illness and mortality statistics. There is evidence to suggest that the widowed are a population at risk in regard to the development of acute symptoms and increased mortality rates, especially during the first six months of bereavement (Maddison and Walker, 1967; Parkes, 1965, 1970, 1975a, 1975b; Clayton et al., 1974; Vachon, 1976; Blanchard et al., 1976; Black, 1978; Ramsy, 1979).

Parkes (1965) states the following:

> Of all functional mental disorders almost the only one whose cause is known, whose symptomatology is stereotyped and whose outcome is predictable, is grief. (p.1)

Central to Parkes' viewpoint is that "normal grief is an illness." Blau (1975), Clayton (1968), Maddison and Raphael (1972) are among those who support this viewpoint. Contrary to the approach that bereavement is an illness is the approach which stresses bereavement and grief as a normal reaction to a loss as a result of death. This approach is expressed by Schmale (1972):

> Since bereavement is not, in and of itself, a disease but a natural psychological process which involves a series of steps that lead to a giving up of the lost object and the capacity to look for a new one, there is nothing to manage, treat or control (p. 807)

These researchers agree that grief is an important and necessary reaction to a loss, especially a loss through death of a significant other. It is a process enabling the person who suffered a loss to eventually accept the realization that things are different (Lindemann, 1944; Hodge, 1972; Parkes, 1975a; Black, 1978; Ramsy, 1979). A similar process comprised of various phases was identified as occurring among the dying (Kobler-Ross, 1969). The difficulty in drawing the line between "normal" and "pathological" grief lies in the fact that many grief reactions are more clearly seen during the initial phase of the bereavement process than at a later period of time. The bereaved persons go through an intensive experience, at most times unfamiliar to them, which involves strong emotional reactions. The need for social support is very important, although most often not understood by others surrounding the bereaved person.

Silverman (1969, 1975) sees grief as part of the human condition. It is not an illness from which one can be cured. Lopata (1971, 1975) pointed out that most of the work on the effect of death on survivors had been conducted in the past by psychiatrists and psychologists, mostly on the symptomatology of the bereavement process. Very little attention had been paid to grief work and to directions it can take in "normal" people. In Schmale's (1972) opinion, if the individual is unable to complete the process of grief, "therapeutic interventions may be appropriate to what could be called 'abnormal and atypical' bereavement reactions" (p. 807). He lists factors influencing the grief process, such as cultural and social factors, mode of death (sudden and unexpected, as opposed to anticipated death following a prolonged illness), age, and role of the bereaved. Other writers have also mentioned those factors as affecting the grief process and bereavement outcomes (Parkes, 1970; Vachon, 1976; Williams, 1972). Bereavement outcomes are the patterns and reactions - emotional, psychosocial and physical - following the loss. Parkes (1975a,b), in particular, has cautioned that there is a strong relationship between mode of death and bereavement outcomes. On the basis of his studies, he concludes that a sudden and unexpected death of a spouse results in a greater stress, especially among young widows, than does an anticipated death of a spouse. Unexpected death constitutes a special risk to psychological and social adjustment.

As was mentioned earlier, psychological and social adjustment to the new reality and its acceptance involve changes in the self-concept

as well as the bereaved person's external world relationship. It is the interaction between psychological processes and the social network, especially during the immediate crisis, that influences bereavement and outcomes (Maddison and Raphael, 1972; Schmale, 1972; Vachon, 1976; Ramsy, 1979). Moreover, Maddison and Walker (1967) found that a major factor affecting bereavement outcomes among widows was their perception of help - the supportiveness of the interpersonal relationship during the initial stage of bereavement. "Good outcome" widows were differentiated from "bad outcome" widows in their perception of such support.

The importance of these findings can be further understood in relation to the loneliness and social isolation of widows, who frequently encounter difficulties integrating themselves into society. In a couple-oriented and function-oriented society, which values upward mobility, widowhood produces a change in roles and changes in identity and life patterns when partnership is dissolved. The widows face minimal support for both the crisis and provision of alternatives in terms of roles, at times when most needed. Widows constitute a minority group facing discrimination and difficulties in social participation (Lopata, 1971, 1973; Maddison and Raphael, 1972; Vachon, 1976; Golan, 1975).

Statistical data reveal that widows outnumber widowers by almost two to one. Among reasons cited are women's longer life expectancy and the fact that men commonly marry women younger than themselves. Also, remarriage rates are higher for widowers than for widows

(Vachon, 1976; McCourt et al., 1976). The average life expectancy in the United States is currently 76 years for women and 68 years for men (Maracek, 1976). VanCoevering (1973) points out that, although widowhood has attracted little attention, one of every five women who face conjugal bereavement will need professional help in order to return to a state of physical and mental well-being. Though it should not be implied that the adaptation process of widowers to bereavement is less complicated, it seems to the researcher that widows face somewhat different problems and additional stress.

Silverman (1975) notes that bereavement and widowhood involve two interrelated aspects. One refers to the emotional reaction and to the loss of a spouse, whereas the other is the result of such a loss and involves changes in roles for the survivor. Thus, bereavement includes not only the widow's ability to accept the reality of the loss but also the adaptation to the new roles involved. The widow is faced with role transition problems, which are personal and social consequences of bereavement. Aslin (1976) refers to such a state as a "no role" phase (p. 61), which results from traditional female sex role socialization. The traumatic nature of grief and the process of bereavement seem to be related to a rather complex combination of factors. Changes in roles, self-concept, and identity are related to social and environmental factors as well as to the widow's perception of grief. Although the loss of a spouse is a very personal experience, the adaptation to the loss occurs on the interpersonal

level. The availability of the social network is of great importance (Caplan, 1974; Caplan and Killilea, 1976).

The approach underlying the present study is Ziller's (1973) "self-other" orientation, based on his social-self theory. The theory emphasizes the social nature of the self and assumes that demands for individual adaptation are primarily social in nature. Thus, the self is viewed in its social context. Also, this approach assumes that major life events are experienced by the individual in relation to the social environment. In viewing a loss of a spouse as a major and traumatic life event, the researcher proposes that the individual's self-esteem is a component of the self system and is highly related to the social environment. Persons with high self-esteem control their environment rather than being totally dependent upon it, whereas persons with low self-esteem are dependent on their environment and are controlled by it. Both high and low self-esteem indicate a strong "self-others" relationship.

The internal-external control dimension (Rotter, 1966) refers to persons' response to a situation as either controlled by chance, luck, fate, or controlled by their own behavior. Rotter, Seeman, and Liverant (1962) observed that individuals differ in the degree to which they believe themselves to be rewarded by their own efforts or by forces beyond their control. Accordingly, persons who respond to positive and/or negative events as if they are consequences of their own actions, and therefore under their personal control, are those who have an "internal locus of control." By contrast, persons who act as

if events that happen to them are unrelated to their own behavior, and therefore beyond their personal control, are those who have an "external locus of control." The measurement of individual differences in locus of control has been accomplished by a forced-choice questionnaire, the Internal-External Control Scale, which has evolved through a series of revisions into a 29-item inventory, including six filler items (Rotter, 1966). Rotter suggested, on the basis of a series of studies, that there is "a strong support for the hypothesis that the individual who has a strong belief that he can control his own destiny is likely to (a) be more alert to those aspects of the environment which provide useful information for his future behavior; (b) take steps to improve his environment condition; (c) place greater value on skill or achievement reinforcement and be generally more concerned with his ability, particularly his failures; and (d) be resistive to subtle attempts to influence him" (Rotter, 1966, p. 25).

Within this framework of interactions between self and significant others, Landsman's (1968) studies of human relationship experiences are of special importance. Human relationship experiences were found to be involved in 47.7% of the responses studied. Also, studies on turning-point experiences (Fuerst, 1967), negative experiences (McKenzie, 1965) and intense experiences (Lynch, 1968) reveal that the death of a "significant other," which is a negative experience, is often reported as a turning-point for a positive experience with the presence of a helping person. Landsman commented:

"Though we cannot shield our children from natural or accidental disasters - such as death of a parent, we can transform the effects of these events so as to be strengthening rather than personality shattering" (1968, p. 13). Cadden (1974) in an unpublished paper states that, in a crisis the outcome of a disaster is not predetermined by the person's character or "inner strength" but by the kind of help the person receives during the trouble. Cadden says: "During the short period in which the balance of forces is teetering, a slight helping hand can mean the difference between a good and a poor outcome" (p. 1).

The assumption underlying the present study is that bereavement is a normal process and that grief is an important and necessary aspect of it. Central to the study is the question of what constitutes positive and negative outcomes of grief resolution and bereavement adaptation. These outcomes are approached phenomenologically, and the study examines the adaptation process to bereavement from the widow's subjective viewpoint. The self-other approach undertaken in the present study enables further exploration of the widow's self-esteem in terms of her interaction with the social environment. Her adjustment and learning patterns are also studied in terms of internal-external locus of control. Additionally, a third dimension focuses on the analysis of social support at times of traumatic experiences, such as a loss of a spouse. This dimension includes the widow's report of helpful and unhelpful experiences as she perceives them, her ability to utilize the support and help, and

the relationship to the other two dimensions - self-esteem and internal-external locus of control.

CHAPTER TWO
REVIEW OF RELATED LITERATURE

Research studies indicate that bereavement refers to a process in which the individual person, the bereaved, experiences what has been identified as grief reactions. Grief work has been stressed as necessary and unavoidable in order to adapt to reality and to reorganize one's life in terms of self and others (environment) following the loss. These reactions are commonly known to occur in stages, in which the time dimension is of primary importance. Inability to do grief work can potentially cause health deterioration. There is evidence to suggest that bereaved persons are a population with a high mortality and morbidity risk. A loss such as a death is regarded as the most traumatic event along the continuum of loss and separation. Factors affecting bereavement outcomes include the mode of death, age of the survivors, personality characteristics, socio-economic factors, previous experiences of loss and separation, and health factors. Many recent studies show that an important dimension of bereavement and its outcome is related to the interaction between the bereaved person and his or her environment. In other words, it is suggested that a combination of factors such as mode of death and age of the survivors during the process of bereavement is highly relevant to the social network in which the bereaved person is situated (Maddison and Walker, 1967; Silverman, 1975; Parkes, 1975a,b; Peterson & Briley, 1977; Faschingbaur et al., 1977).

Definitions, Stages and Sociology of Bereavement

Bereavement, grief, and mourning are terms related to experiences of loss, specifically loss as a result of death. In the literature the terms bereavement, grief, and loss are interchanged without clarity about the meaning in the specific context.

Caroff and Dobrof (1975) stress the importance of clarity and precision in using the different terms with bereaved families, who go through a universal and awesome experience. Caroff and Dobrof make a clear distinction between bereavement and grief - the former referring to a state of desolation, and the latter to the emotional reaction of deep sorrow or sadness, caused by trouble or loss (p. 233). Bereavement is defined as a loss or separation from an object depended upon for sustenance. Epstein et al. (1975) give the following definitions: "Bereavement refers to the complex reactions of survivors following the experience of separation by death of a significant person" (p. 537). Averill (1968) points out the distinction between grieving and mourning. Mourning is described as the process sanctioned by culture and custom, instructing individuals as to what they must do and how they must behave at the time of loss. Grieving, on the other hand, is treated as a pancultural biological process, universal in its forms, manifestations, and processes.

Grief is defined as "keen mental suffering or distress over affliction or loss, sharp sorrow, painful regret" and mourning as "the conventional manifestation of sorrow for a person's death" (Random

House Dictionary, 1960). Freud (1917) considered grief work to involve the painful task of decathecting libido from a lost object and reintegrating it in a new reality.

Grief work, according to Lindemann (1944), is that "emancipation from the bondage to the deceased, readjustment to the environment in which the deceased is missing and the formation of new relationship" (p. 143). Schmale (1972) saw bereavement as a process of working-through, which involves a change in one's self-concept, aspirations, and goals and a change in one's external world of relationship (p. 807).

The process of working-through is characterized by phases or stages. Bowlby (1961) suggested the following three stages of mourning. The first stage is characterized by numbness, disbelief and attempt to deny the reality of the loss. Bowlby has revised his description of this stage, which he formerly defined as a stage of denial. The second stage is characterized by reluctant acceptance coupled with disorganization of personality. Feelings may range from extreme sadness, loneliness, and helplessness to anger towards the deceased and those alive. The third stage is characterized by reorganization of the personality. The person has a sense of weary relief in having worked through bitter grief emotions.

A person, however, can remain fixated at any stage. The third stage may even be reached prematurely without the person's having thoroughly worked through or resolved previous stages. There are no

shortcuts in grief. Lindemann (1944) and Parkes (1970) support this view with their findings which reveal a close relationship between unresolved grief and various degrees of personal disability.

Lindemann (1944) considers grief work as necessary for resolution of bereavement even if at times grief is denied or delayed. This position is supported also by Deutsch (1937), who views the process of mourning as a reaction to the real loss of a loved person, a process that must be worked to completion. Hodge (1972) describes ten stages of grief and insists that, unless all stages are expressed, illness may result. The stages are (1) shock and surprise. (2) emotional release, (3) loneliness, (4) physical distress with anxiety, (5) panic, (6) guilt, (7) hostility and projection, (8) lassitude, (9) gradual overcoming of grief, and (10) readjustment to reality.

The acute phase (from shock through lassitude) is normally completed from six to twelve weeks after the loss, and the entire process should be completed within two years in a healthy situation. There is much discussion among writers as to the time dimension involved in the completion of the grief process. It is agreed that the first few weeks involve the most intensive reactions to the loss but mourning can last for several years before its completion (Parkes, 1970; Maddison, 1968; Silverman, 1975). It is obvious that the range of time is very wide while at the same time very individual. Silverman (1969) suggested that the initial stage, described as the

shock separation period, lasts between one and six days. It is followed by intense grief, which can take from a month to a year to dissipate. The third stage, the recovery stage or acceptance of the loss, can take from three months to a year.

The Halacha-Jewish legal system based on Mosaic law offers a framework of mourning and bereavement (Shindler, 1977). The framework creates a structure in which the bereaved receive support from friends and relatives. It takes into consideration the different needs of the bereaved person at different stages or phases of the bereavement process. The first of five stages is "Aninut," the period between the death and the burial. In the second stage, "Eulogy" or "Rending of the Garments," the bereaved begin to deal with their grief. The third stage, "Shiva," is characterized by visits of friends and relatives to honor the deceased and comfort the bereaved. At this stage, which lasts for seven days following the burial, the bereaved is supported by relatives and friends. The fourth stage, "Shloshim" is the 30 days following the burial (including the seven days). During this stage the bereaved are gradually returning to themselves and society. The fifth and final stage takes place twelve months following the burial when all mourning is ended by a memorial service to the deceased (Shindler, 1977).

These mourning stages are analogous to the bereavement stages identified in the literature and to the five stages of the process of dying as delineated by Kobler-Ross (1969). However, the observance of

mourning stages as set by Halacha differs to a great extent among various ethnic groups within Israeli society, and the observance now reflects the general tendency in contemporary society to place less importance on mourning rites and ceremonial observances.

Cultural, social, and demographic changes in contemporary society have also influenced the process of bereavement. The changes in mourning rites and ceremonial observances have created considerable difficulties in coping with both death and bereavement. Additionally, demographic changes in modern society, which include a low birth rate and a low death rate, imply that families experience the events of birth and death less frequently and thus have less experience in learning how to cope with death and bereavement (Vachon, 1976; Caroff and Dubrof, 1975; Maddison and Raphael, 1972). These issues are further aggravated by socio-economic problems (Maddison, 1968; Vachon, 1976). Harvey and Bahr (1974) conclude that most of the negative impact of widowhood, including lowered morale and decrease in affiliates, is more directly correlated with change in income than with change in marital status.

Bereavement: an Illness or a Normal Process

There is a conceptual dilemma as to the nature of grief and bereavement. On one hand, death is clearly a crisis which forces the individual to extreme and difficult cognitive and emotional reactions. On the other hand, it is recognized as a normal and necessary process that enables an adaptation to and acceptance of the loss.

Schmale (1972) states: "If the individual is unable to complete the process, therapeutic intervention may be appropriate, but no study has attempted to evaluate systematically the specific therapies appropriate to what could be called abnormal and atypical bereavement reactions" (p. 807).

Hodge (1972) describes grief as a definite psychiatric syndrome with a characteristic onset, course, duration, and termination. Parkes (1965) also sees grief as a normal illness. Maddison and Raphael (1972) support Engel's (1961) viewpoint in considering grief as an illness and as such it becomes a legitimate subject for scientific study. There are two approaches to the phenomenon of bereavement. The majority of studies deal with the symptomatology of bereavement, where psychophysiological indicators are used as criteria in an attempt to measure bereavement patterns and reactions. Epstein et al. (1975) suggest that "a difficulty in establishing normal bereavement rates is a lack of consensus as to which population to regard as the normal control" (p. 538). Other constraints on research, in their opinion, include problems in selecting psychiatric patients for comparison with normals, deficiences in data gathering, failure to consider demographic factors, and interviewing variables. Lindemann (1944) describes acute grief as a syndrome that may appear immediately after the loss event, may be delayed, may be exaggerated or may even seemingly be absent.

Parkes (1965) classified grief into four categories: (1) typical grief, (2) chronic grief, (3) delayed grief, and (4) inhibited grief. Studies by Parkes (1970, 1965), Clayton and Winokur (1968) and Blanchard, Blanchard and Becker (1976) indicate that bereaved persons are a population at risk. It is stressed that rates of mortality and morbidity increase, especially during the first six months of bereavement. Maddison (1968) studied 132 widows from Boston, United States, and 221 from Sydney, Australia, and compared them with matched controls of married women. Data were collected by means of a postal questionnaire. Of the total sample of widows, all under the age of 60, 28% showed marked health deterioration, as compared to 4.5% of the married women. Symptoms more common among the bereaved were depression, feelings of panic, fears, nightmares, loss of appetite, loss of weight, and fatigue. Also, 12.8% of the bereaved compared to 1.0% of controls had consulted a physician for treatment of depression during the previous 12 months (Rees, 1972; Maddison and Raphael, 1972; Faschingbauer et al., 1977). These findings are of special importance. Schmale (1972) points out that such reactions are part of normal grief. In his opinion, too frequently physicians tend to offer sedation when it is not needed; this practice may increase the bereaved person's dependency both on the physician and on the sedation. He notes that the emotional reaction of grief work includes (1) no feelings - numb and wooden, (2) anger and fear, (3) helplessness and a desire to be helped, (4) guilt and shame, (5)

helplessness, and finally (6) hope. Factors influencing bereavement outcomes include mode of death of a spouse (sudden and unexpected or anticipated death), nature of relationship the bereaved person had with the lost object, previous medical history, personality characteristics of the bereaved person, expectation and availability of support, and replacement during the various stages of the grieving process. Ramsy (1979, p. 221) has described the following phases: shock, disorganization, searching behavior, emotional component, desolate pining, despair, guilt, anxiety, jealousy, shame, protest and aggression, resolution and acceptance, and reintegration.

Denial, according to Ramsy, plays a part throughout the process: "Many people suppress their feelings, do not or cannot feel guilt, anger, or grief" (Ramsy, 1979, p. 224). The need to grieve is stressed throughout the literature. Lindemann (1944) has observed the difficulty of grieving and the tendency of patients to avoid "intense distress connected with grief experience and to avoid the expression of emotion necessary for it" (p. 143). Hodge (1972) not only emphasizes the importance of grieving but also states that there are no short cuts: "The problem must be brought to the open and confronted, no matter how unpleasant it may be for the patient. The grief work must be done. There is no healthy escape from this. We might even add that the grief work will be done. Sooner or later, correctly or incorrectly, completely or incompletely, in a clear or distorted manner, it will be done" (p. 230).

Parkes (1975a,b), in a study of young Boston widows and widowers, reports that unexpected and sudden loss constitutes a special risk to psychological and social adjustment. A comparison between two groups - persons who experienced sudden death and those who anticipated the loss of a spouse - reveals that over a period of time, large numbers of the "short preparation group" (sudden death of a spouse) are still unable to detach themselves from the deceased spouse. Thirteen months after the loss occurred, only 13% of those who experienced sudden loss were rated as "good" outcomes, and two to four years later the proportion had dropped to 6%, as compared to 60% and 65% in the "long preparation group" (anticipated death). Parkes says: "As in all forms of grief, the initial reaction seems to reflect a deep seated need to search and, if need be, fight to recover what is lost. What is different from typical grief is the intensity and duration of the reaction" (p. 136). According to Parkes, helping professions should do all they can to prepare people for bereavement. Silverman (1969, 1975) and Lopata (1971, 1975) emphasize that, since adaptation to bereavement involves changes in identity and roles, it requires learning.

The relative absence of formal ritual or structured support in contemporary society, as well as social-economic stresses, increases the person's difficulties in bereavement. A majority of the studies concerning widowhood focused on widows, not because it has been assumed that widowers experience fewer difficulties in the process of

bereavement but mainly because widows outnumber widowers and face special difficulties. Widows outnumber widowers because women have a longer life expectancy than men and because women are usually younger than their husbands. The average life expectancy in the United States is currently 76 years for women and 68 for men. Also, among the widowed, remarriage rates are higher for men than women (Vachon, 1976; Maracek, 1976; Briscoe and Smith, 1975).

According to Lopata (1971, 1975), in a couple-oriented society, widows experience a drop in status with the death of their husbands. They are discriminated against because they are widows, and they form a minority group in the sense that they are different from the dominant group. Moreover, they are passive females, lacking a defined function in a male-dominated, function-oriented culture. This culture values upward mobility, but frequently the widows, especially old widows, experience a downward mobility. Lopata says: "The process following widowhood is the process of redefinition of the past and of the self in its current environment. Grief work requires a complete rebuilding of the fabric of life, necessitating changes in images of self and significant others" (p. 74). Central to this problem is the change in the widow's identity, which was derived to a great extent from her interaction with her husband both socially and economically. Most of all, a loss of a spouse indicates loss of identity and a loss of a role.

Silverman (1975) states: "It is necessary to learn to be a widow as one learns to be a wife or a mother. We are accustomed to thinking

of 'working at' being a wife and a mother, which involves including additional people in one's life. Widowhood involves working at living without. People rarely think of becoming widowed in this way. Often the newly bereaved is expected to know immediately how to behave in this role, to have acquired knowledge in an almost magical way. Actually the transition is difficult and many are in need of help. Part of finding a role as widow is the need to find a way, a bridge back to reintegrate her life in the broader community" (p. 10-11).

Loneliness is one of the greatest problems of the widowed. Low morale, personal isolation, unhappiness, and feelings of loneliness are associated with widowhood (Harvey and Bahr, 1974; Lopata, 1975; Vachon, 1976). VanCoevering (1973) reports that demoralization cuts across all income levels, extends to both working and non-working widows, to the disengaged and the socially active, and to all age groups.

Despite the numerous personal and social problems of widowhood, most widows eventually seem to adapt to their change in status. Lopata (1971) found that among women who have been widowed for some time, many believed themselves to be more independent, active, and competent than when their husbands were alive. Variables associated with a positive adaptation are weekly contacts with a friend, childhood perceived as happy, good self-image, educational attainment at high school level, optimistic mood tone, and evidence of having made a shift from a life-focus on past experiences to the present and future (VanCoevering, 1973).

Similar opinions regarding changes in self-concept and role adaptability among widows have been stated throughout the literature. (Aslin, 1976; Schmale, 1972; Parkes, 1965) Maddison and Walker (1967) found that "bad outcome" widows were those who perceived their social environment as unhelpful as compared to "good outcome" widows, who perceived their social environment as helpful. This finding suggests that bereavement outcomes are the interaction between psychological processes and the social network (p. 1062).

Widowhood and Bereavement Adaptation

Maddison and Walker's (1967) study investigating factors affecting the outcomes of conjugal bereavement also examined the relationship of the bereavement outcomes to the widow's experience and to her perception of the interpersonal supportiveness during the crisis. The study compared the widow's subjective report of her health - the criterion of bereavement outcome - with her perception of help and support. It was found that widows who resolved the crisis in a healthy manner differed from those with a bad outcome in their perception of support. There were significant differences between groups, good outcome widows tending to perceive permissive support as helpful and bad outcome widows appreciating more active encouragement from the environment. Also, bad outcome widows tended to perceive the environment as actively unhelpful, the relevant interchanges usually involving either the blocking of a widow's expression of affect, or overt or covert hostility directed towards her (p. 1065).

In the present study, a socio-psychological approach emphasizes the interrelationship between the widow's perception of herself as well as her perception of her social environment, focuses on the self-other interaction, and emphasizes the self-esteem component. Brown and Harris (1978) found that self-esteem is a major factor influenced by what is referred to as "severe life events." Among severe life events that have the potential of causing a depression, they note bereavement and separation. Moreover, they identify vulnerability factors, which include the lack of an intimate or confiding relationship. Amir and Sharon's (1979) findings about the social-emotional aspects of adaptation to bereavement among war widows indicate that social functioning is an important predictive factor, not related to basic personality characteristics.

Ziller's (1973) theory of personality social adaptation is presumed to be mediated by self-other concepts. His self-other theory offers an integrative approach, whereby the individuals are viewed in their social setting and their self is evaluated in terms of a social frame of reference provided by significant others (p. 6). Ziller proposes that the self is a mediating agent between the organism and the environment and that self-esteem (defined as the individual's perception of his worth) is the component of the self system associated with the consistency of the organism's response to the environment. Ziller says: "Self-esteem is a cognitive orientation of the self in relation to significant others along an evaluative

dimension chosen by the evaluator himself. This orientation then, serves to organize and assimilate social stimuli and serves as the basis for social behavior" (pp. 8-9).

Ziller employs a phenomenological orientation, which stresses the individual's point of view and its evaluative component but within a social frame of reference. In this context, self-esteem is that component of the self system which is associated with the consistency of the organism's response to the environment. Moreover, self-esteem is a component involved in the regulation of the extent to which the self system is maintained under conditions of strain, such as processing new information relative to the self. Ziller says: "Even if the information is accepted, a person with high self-esteem will tend to assimilate the information rather than restructure the self system. In this way, persons with high self-esteem are somewhat insulated from the environment or are not completely subject to environmental contingencies. The individual is not a victim of events or does not feel compelled to accommodate the self to the situation. Events are assimilated within the self system" (p. 7). A person with low self-esteem is "field dependent, that is, he tends to passively conform to the influence of the pervasive field or context. Low self-esteem is associated with short term adaptation and inconsistency, whereas high self-esteem is associated with long range adaptation and consistency" (p. 7). Self-esteem is one component of the self system, which is viewed here as a personal-social system.

Individuals differ in their perception of how much control they have over the environment.

Rotter, Seeman, and Liverant (1962) have studied the extent to which individuals believe they have control over their attitudes and behavior. Their study is based on their observations of patients in psychotherapy. Their analysis revealed that while some patients appear to gain from new experiences or to change as a result of new experiences, others seem to discount new experiences by attributing them to chance or to others rather than to their own behavior or characteristics (p. 474). Rotter (1966) has developed the Internal-External Control Scale based on his social learning theory, in which the general expectancy is related to persons' beliefs as to the degree of responsibility and control they have over different situations. One end of the continuum includes individuals who interpret the various events as a result of their control and responsibility (internal control) whereas at the other end are those who explain those events as controlled by external forces such as luck, fate, and chance (external control).

Lipp, Kolstoe, and Randall (1968) suggest that the Internal-External Control Scale can differentiate denial responses among the disabled. In their study, using a tachistoscope, they introduced pictures of 15 disabled people as a threatening stimulus and pictures of 15 healthy individuals as a non-threatening one. They found that externally controlled subjects denied their disability less

than internally controlled subjects did. The writers propose that physical disability is more threatening to individuals who believe they have control over various events.

Adaptation to a loss of a spouse requires the use of inner resources as well as external support and help from significant others. The death of a spouse is beyond the control of the widow, regardless of the level of internal or external control or her level of self-esteem. However, the levels of internal-external control and self-esteem might be indicative of her adaptation patterns and her ability to utilize help and support during the process of bereavement. Therefore, examining both levels of self-esteem and internal-external control and their relationship to widow's perception of helpful and unhelpful experiences can help counselors to understand better the various dimensions and patterns of adaptation to bereavement.

Landsman's (1968) theory on positive human experiences offers strong support to Cadden's (1974) viewpoint that the kind of help provided in a crisis, rather than the person's innate character, can explain a detrimental outcome. According to Landsman, the most frequently reported experiences were human relationship experiences (47.7% of 681 respondents). In addition, Landsman says: "The frequency and intensity of positive experiences in the life history of the person are critical to the etiology of the beautiful person ... Negative experiences or crises which have had positive effects are

also involved in the beautiful person" (p. 1). Landsman continues: "It seems a reasonable hypothesis that most of the experiences which foster maximal adjustment or personal fulfillment are with fellow human beings" (p. 3). Also, negative human experiences have the potential to close or to open the self to the world. Landsman stresses the following:

> Negative human experiences hold potential for:
> A. Immediate closing of self to the world in both directions, active and passive (permitting people and ideas to have access to one's self and reaching out to people and for ideas).
> B. Or it leads to a temporary closing of the self followed by a specific, more intense opening. This second possibility, the change of meaning of an experience from negative to positive, occurs when a sensitive helping person (such as a counselor or a friend) intervenes to provide self-understanding at a critical moment in the negative experience. Suffering-closing experiences were found to be involved in 50.2% of the narratives (Lynch, 1968) and 35% of experiences with others were reported as a turning point from a negative to a positive experience (Fuerst 1967). In Fuerest's study it was found that the most frequent single kind of experience reported as being a positive point in one's life was the death or illness of a relative. "The anatomy revealed includes the existence of negative-negative experiences and the negative-positive experiences and in particular the more frequent, statistically significant, presence of a helping person for those events which became positive. (1968, p. 13)

Recently it has been suggested that the bereavement process is a transition in life. Such an approach offers a broader view of the concept of crisis, suggesting that the process contains a succession of short crisis periods over a long period of time (Caplan, 1974; Shneidman, 1972). Parkes (1975a) suggests that bereavement can be viewed as a "psychosocial transition," like childbirth, retirement, marriage, and migration. These events involve major changes in life,

have lasting consequences, and affect large areas of the assumptive world.

In terms of crisis theory (Caplan, 1964), bereavement refers to a state of the reacting individual and/or group at a turning point in a hazardous situation which threatens integrity or wholeness. Old habits are disturbed and new ones will be developed, the outcome of which may be either positive or negative (Williams, 1972; Flesch, 1975; Peterson, 1977). Adaptation to bereavement may then be viewed as a process which is determined through the interaction between the person's resources and the relationship he or she experiences with significant persons. In Insel's opinion (1976), adapting to the death of a loved one can be and often is what he calls "an integrating experience" for the survivors; counselors have the opportunity to facilitate this direction if they themselves are so oriented.

Although some studies indicate the importance of help and support during bereavement, relatively little research has been done in this area. Most studies focus on the symptomatology of bereavement, and the intervention models are directed towards pathological aspects of bereavement with medication (tranquilizers and sedatives) as a mode of treatment (Schmale, 1972).

The present study assumes that the loss of a spouse is a traumatic event which requires a process of bereavement and that the support system plays a significant role in the outcome.

CHAPTER THREE
METHODOLOGY

Definitions

The following are a number of terms utilized in this study; some may have different meanings in other contexts.

Bereavement - For this study the term is defined as a reaction to the sudden loss of a spouse through death in war (October, 1973) or on military service (regular or reserve forces). Women who had been widowed in 1973 or thereafter but widowed for more than one year at the time of the interview were included.

Demographic Questionnaire (D.Q.) - A set of questions (# 1-27) used to obtain demographic information about the respondent as well as information regarding her physical health and social activities following the sudden death of her spouse.

Reported bereavement adaptation - Information regarding the widow's bereavement experience which came from her reports relating to her social functioning following her husband's sudden death and her perception of the social support during that time. The term was defined as the widow's subjective report of the level of difficulty in coping with one or more of the following: activities at home; relations with her family and her deceased husband's family, old and new friends, and her children; going out to work; and difficulties with finances (Questions # 21-26 in the D.Q., Appendix C).

Reported physical health status - The widow's own report on her physical health status immediately following the loss of her husband and at the time of the interview, specifically in relation to the use of medication, visits to the doctor, changes in appetite, eating, and sleeping habits (Questions # 13-20 in the D.Q., Appendix C).

Self-esteem - Degree of positive or negative attitude toward self. This term is defined according to the total scored number of the widow on the self-esteem (SE) sub-scale of the Self-Other Orientation Tasks by Ziller (1973). See Appendix A.

Internal-External Control Scale - The degree of control the widow has, or thinks she has, over events. Widows who see events as beyond their control (luck, fate) are referred to as "externals," while widows who believe they are in control are termed "internals." The widow's position on the Internal-External Scale (Rotter, 1966), is either internal (I) or external (E). See Appendix B. Those widows scoring at or above the median score are referred to as "internals" and those widows scoring below the median score as "externals."

Helpful experiences - All reported experiences with significant others which are subjectively perceived and recognized to be supportive, comforting, or encouraging by the widow following the loss of her spouse.

Unhelpful experiences - All reported experiences with significant others which are subjectively perceived and recognized to be painful, discouraging, or dissatisfying by the widow following the loss of her spouse.

Grief and grief work - A process which includes emotional expressions by the widow following the sudden death of her spouse. Emotional reactions such as despair, shame, anger, protest, and guilt are expressed verbally and non-verbally. These reactions are essential components for the resolution of the loss and the acceptance of the new reality which does not include the dead husband.

Resolved grief - A gradual decrease of intense emotional reactions of anger, despair, and criticism, indicating the widow's acceptance of a new reality which excludes the dead husband.

Unresolved grief - Difficulties in resolving and accepting the reality of the death of spouse which persist in expression of intense emotional reactions such as anger.

Mourning customs (Min'hagei Av'lut) - Jewish mourning and bereavement framework based on Halacha (Jewish legal system derived from Mosaic law). The five stages, spread over a period of the first 12 months, are the following: The first twenty-four hours - "Aninut", the "Shiva" - seven days, the "Shloshim" - thirty days, and a memorial service at the end of the twelve months which marks the end of the process.

Bereavement as a normal reaction to a loss of a spouse is a traumatic human experience that requires a two-dimensional adaptation: rebuilding one's identity and redefining one's role in relation to significant others, as well as to the general social network. It is assumed that social support is an important source of help for the bereaved person. Caplan and Killilea (1976) point out that the availability of a helping hand at times of crisis can determine the difference between a positive and negative outcome.

Most studies are based on the assumption that bereavement is a "normal illness" and stress the potential risks of morbidity and mortality among the bereaved. Recently it was suggested by Caplan (1974) that bereavement involves a series of common stages, "transition in life." In the studies of bereavement adaptation, relatively little research has been done on the relationship between the widow's subjective bereavement experience and self-esteem. Moreover, little attention has been given to whether there are differences in bereavement patterns between widows who are able to take responsibility for rebuilding their lives (internal locus of control) and those who do in fact deal with the situation as if it was beyond their control (external locus of control).

The bereavement process involves the experience of grief including psychophysiological reactions. Most bereaved people experience these reactions. Yet because these reactions are so intense, people attempt to avoid them. Hence reactions such as loss

of appetite, loss of weight, headaches, and insomnia as described by Parkes (1965) are treated as symptoms rather than normal reactions. On one hand, referral to physicians because of these reactions is less threatening; on the other hand, most physicians see these reactions as symptoms and treat them as such (Schmale, 1972). There has been little research on the widow's subjective perception and reports of her experiences with the social network - what are perceived and reported by her as helpful or unhelpful experiences with significant others during the bereavement process and their relationship to adaptation. The present study sought to find out if the widow's reports of experiences with others were related to her level of self-esteem and her locus of control.

A descriptive research design was used in the present study. Issacs and Michael (1971) point out that the purposes of descriptive studies are as follows:

1. To collect detailed actual information that describes existing phenomena.
2. To make comparisons and evaluations.
3. To identify problems or justify current conditions and procedures.
4. To determine what others are doing with similar problems or situations and benefit from their experience (p. 18).

Research Questions

The study was designed to investigate six questions. All are related to the effect that certain personality characteristics have on the level of bereavement adaptation of widows who experience a sudden loss of a spouse.

Self-esteem and Locus of Control

There are wide individual differences in response to a traumatic experience such as a sudden loss of a spouse. Through self-esteem and internal locus of control scores, a direct comparison can be made between objective measures and the widow's subjective report of bereavement experience. (Self-esteem refers to the widow's perception of herself in relation to others, and locus of control refers to her pattern of responses to the event.)

1. What is the relationship between the level of self-esteem and the widow's reported bereavement adaptation (Questions 21-26 in the Demographic Questionnaire)?
2. What is the relationship between the internal versus external locus of control and the widow's reported bereavement adaptation (Questions 21-26 in the Demographic Questionnaire)?

A widow with low self-esteem who has experienced a sudden loss of her spouse might report greater difficulties during the process of bereavement in her relations with her children, family, in-laws, and friends than would a widow with high self-esteem. Similarly, a widow who responds to events as if they are unrelated to her own behavior

might adapt differently, and therefore report different bereavement experiences, than would a widow who responds to events as if they are the consequence of her actions.

Physical Health

The bereavement process involves psychophysiological reactions. Loss of appetite, headaches, and insomnia are regarded as normal reactions. Other emotional reactions are numbness, yearning, and searching for the dead person. The intensity of these reactions decreases as time passes. The study considers differences in reported physical health status during the bereavement process among widows with high and low self-esteem as well as among widows with internal and external locus of control.

3. Do "high and low self-esteem" widows differ in their reported physical health status (Questions 13-20 in the Demographic Questionnaire)?

4. Do "internal and external locus of control" widows differ in their reported physical health status (Questions 13-29 in the Demographic Questionnaire)?

Social Support

The importance of social support is stressed in the literature (Maddison and Raphael, 1972). The study is not restricted to what is assumed to be helpful or unhelpful, but explores differences about what the widows perceive as helpful or unhelpful in relation to self-esteem and internal versus external locus of control.

5. Is there a relationship between widows' level of self-esteem and the frequency, intensity, and type of their reported helpful and unhelpful experiences?
6. Is there a relationship between widows' internal versus external locus of control and the intensity and type of their reported helpful and unhelpful experiences?

Population

Since the establishment of the State of Israel, four wars have occurred and the phenomenon of sudden loss has become a well known reality. Many bereaved families, widows, and orphans have resulted from these conflicts.

All bereaved families who lose their sons, husbands, or fathers through wars or during military service (regular, reserve or national service) are eligible for social and financial services delivered through the Rehabilitation Department of the Ministry of Defence. They are referred to as I.D.F. (Israel Defence Forces) bereaved families. The services, established by law, include comprehensive social and financial care. Financial assistance to widows includes a monthly income, assistance with current debts, and help in purchasing new housing and furniture. Also provided are reduction or cancellation of purchase taxes and custom duties, supplementary medical and dental care, and free higher education for orphans (higher education is not state-subsidized in Israel). In addition, in the event of a widow remarrying, a "dowry" is provided in the form of a grant to assist her with the expenses involved (Golan, 1975).

The socio-economic variable has been widely stressed in the literature as a crucial factor affecting bereavement adaptation (Harvey and Bahr, 1974). This variable would not affect women who lost their soldier husbands because they are the only group of widows in Israel eligible for comprehensive financial assistance.

According to an official report of the State Comptroller's Office (1974), since the War of Independence (1948), some 3000 women have lost their soldier husbands. From the total number, it is estimated that about 25% of the widows remarried, an additional 25% were still single and have no children. The remaining 50% of the widows have one child or more.

As a result of the increasing number of bereaved families following the 1973 war, as well as an attempt to improve the help given to these families, the Rehabilitation Department has extended its services by adding sub-branches, i.e., services are delivered through smaller regional areas. Prior to the extension of these services, a certification and implementation of financial benefits and a periodic visit paid to the bereaved families' home in official ceremonies were about the only routine duties carried out by the Department of Rehabilitation. A greater effort was made following the 1973 war to understand better and help bereaved families (Golan, 1975). An important opportunity is a visit to a bereaved family's home during the initial period between the "Shiva" and the "Shloshim" (during the first seven days and the thirty days following the burial of the deceased). Its aim is not only to certify and implement

financial benefits but also to establish an initial relationship between the bereaved family and the professional person.

Sampling and Selection Procedures

A total of 51 widows were interviewed in the present study. All live within the regional district which covers the southern part of the central area of the city of Rehovot. The Rehovot sub-branch of the Department of Rehabilitation (Ministry of Defense), where the addresses of the widows were obtained, delivers services to all bereaved families living in the district.

Of the 141 women who were widowed during or after October 1973, 53 were excluded from the sample for the following reasons:

21 remarried,

11 were widowed one year or less at the time of the interview,

10 had no children,

2 were over the age of 50,

9 lost their spouses following a prolonged hospitalization (anticipated death of a spouse),

15 were interviewed by the researcher as candidates for group counseling. (Data collected during these interviews were used for purposes of training the raters (see pp.52-57).

The rationale for excluding widows with these characteristics was based on the following: (1) Widows who remarry are not routinely counseled by the rehabilitation service. (2) Women who have been widowed one year or less experience bereavement reactions which are more intense than those who have been widowed a longer period of time.

(3) Widows with no children face somewhat different problems, which include relationships with their in-laws. It is generally assumed that most of these young widows will remarry very soon after the loss. (4) Most widows over the age of 50 have older children living away from home, a situation necessitating an additional adaptation process. (5) Widows who lost their spouses following a prolonged hospitalization experienced an anticipated death, a situation which has a different effect than a sudden death.

Of the 73 widows included in the sample, 51 (70%) were individually interviewed. Of the 22 (30%) widows who were not interviewed, 14 refused to be interviewed, 3 widows were about to remarry, 3 moved to another district, and 2 had no telephone and did not reply to the mailed letter.

Collection of Data

A letter explaining the general purpose of the study was mailed by the researcher to all widows qualified to participate in the study (Appendix E). A telephone call was then made by the researcher. The widow was asked whether she would agree to participate in the study. An appointment was made for an individual interview with those widows willing to participate. The interview was conducted by the researcher at the widow's home. The interview, lasting one and a half to two hours, included an unstructured part for the purpose of establishing rapport with the widow, followed by the administration of the questionnaires in the following order: (1) the Demographic and Physical Health Questionnaire, (2) the Researcher's Questionnaire,

which was read to the widow and completed by the researcher, (3) the Self-Other Orientation Tasks, completed by the widow and (4) the Internal-External Control Scale, also completed by the widow.

Instrumentation

The self-esteem component of Ziller's Self-Other Orientation Tasks - the Adult Version (Ziller, 1973), a combined Demographic and Physical Health Questionnaire, the Researcher's Questionnaire, and the Internal-External Control Scale (Rotter, 1966) were used in the research study.

The Self-Other Orientation Task (Appendix A), an instrument developed by Ziller (1973), is non-verbal and self-administered. As a non-verbal instrument it has a specific advantage for the present study as it was conducted in Israel where the spoken language is Hebrew. The instrument has three versions: adult, adolescent, and child. The child's version was translated into Hebrew and used in a study with Kibbutz children (Ziller, 1973, pp. 112-116). The adult version was used in the present study and therefore was translated into Hebrew using the procedure used by Ziller and Leslie (Ziller, 1973, p. 115). The test forms were translated into Hebrew by one person and translated back into English by another person to check adequacy of the translation. Where there were discrepancies, the procedure was repeated.

The Self-Other Orientation Tasks is based on the assumption that social adaptation is mediated through self-social constructs. It includes the following components: self-esteem, social interest,

self-centrality, complexity of self, identification, majority identification, marginality, and openness. This is a non-verbal instrument which enables the preservation of the individual's point of view (Ziller, 1974, pp. 310-311).

Only the self-esteem component of the self system was used in the present study. Self-esteem (SE) is defined as individuals' perception of their worth, individuals' perception of control over the environment, and the consistency of their behavior in social situations (Ziller, 1973, p. 9). The SE measure involves the presentation of a horizontal array of circles and a list of significant others such as "yourself," "a leader," and "someone you know who is unhappy." There are six sets of social objects included in the adult form of the instrument. They include (a) doctor, father, a friend, a nurse, someone whom the person knows who is unsuccessful; (b) doctor, father, politician, yourself, an employer; (c) someone who the person knows who is a good athlete, someone whom the person knows who is popular, someone whom the person knows who is funny, someone who knows a great deal, one's self, someone whom the person knows who is unhappy; (d) an actor, your brother or someone whom the person knows who is most like a brother, one's self, a salesman, a politically active person; (e) someone whom the person knows who is cruel, a judge, a housewife, a policeman, one's self, one's sister or someone who is most like a sister; and (f) a defeated legislative candidate, the happiest person whom the person knows, someone who is kind, one's self, someone who is successful, the strongest person whom

Table 1a

Self-Other Orientation Task: The Self-Esteem Measure
Distribution of the Location of the "Negative Significant Others" in Four Items of Self-Esteem Measures. Horizontal Arrangement Position. The Hebrew Version - Right to Left*

	1	2	3	4	5	6
Unhappy N = 88	41%	10%	9%	13%	14%	13%
Unsuccessful N = 88	56%	14%	17%	1%	5%	7%
Cruel N = 88	64%	24%	2%	1%	2%	7%
Flunking N = 88	51%	11%	3%	3%	2%	30%

Table 1b

Self-Other Orientation Task: The Self-Esteem Measure
Distribution of the Location of the "Negative Significant Others" in Four Items of Self-Esteem Measures. Horizontal Arrangement Position. The English Version - Left to Right*

	6	5	4	3	2	1
Unhappy N = 150	16%	7%	7%	7%	15%	48%
Unsuccessful N = 147	21%	3%	5%	9%	5%	56%
Cruel N = 154	27%	2%	4%	1%	3%	64%
Flunking N = 172	31%	1%	2%	3%	4%	59%

* Validation of Self-Esteem Measures: The Hebrew Version - Right to Left. The hierarchical ordering assumes that a location to the left of "Negative Significant Others" is indicating a low status, as opposed to the English version, as was found by Ziller (1973, p. 12).

the person knows. The split-half reliability (odd-even) was 0.80 corrected for length in a study involving 75 randomly selected students from grades 7 through 12. Split-half reliability for the adult form with regard to self-esteem was 0.85, uncorrected for length, involving 70 neuropsychiatric patients. Test-retest reliability for 86 sixth and seventh graders was 0.54 for the student's form (Ziller, 1973, p. 11).

The task requires the subjects to assign each person to a circle. The score is the weighted position of the self. In accordance with the cultural norm, the position to the left is assumed to be associated with higher self-esteem. Validation analyses involved a series of separate studies. One such study by Ziller (1973, p. 12) of the left to right location involved college student subjects. It was noted that the "unhappy person" was placed to the last position to the right 48% of the time, "someone you know who is unsuccessful" 56%, "someone you know who is cruel 64%, and "someone you know who is flunking" 59%. Another analysis by Ziller (1973, p. 14) included the social objects in a horizontal and vertical arrangement. In the vertical display, the higher position of the self is assumed to represent a higher self-esteem. The correlation between these two measures was 0.50 ($N = 82$, $p < 0.05$). According to Ziller the vertical arrangement may introduce greater item visibility. In order to overcome possible differences in the Hebrew version of the instrument, as the Hebrew language is written from right to left, the horizontal arrangement was administered to 88 social work students in

the pilot study. For purposes of establishing the independence of the SE more systematically, the measure was correlated with existing measures of the construct: Bills-Vance Index of Adjustment and Values, Coopersmith's Self-esteem, and Diggory's Self-evaluation (Ziller, 1973, p. 15). As was anticipated, none of the results was found to be statistically significant and "may be interpreted to indicate that the SE and the other measures of self-esteem are in different psychological domains." The SE, in contrast to the other devices, is a non-verbal, low "visibility" instrument and also incorporates a social frame of reference (Ziller, 1973, pp. 15-16).

The score is the weighted position of the self, assigning numbers to the circles 1 to 6 starting at the right. In the Hebrew version scoring is from left to right. Total score of self-esteem is the sum of the six sets of social objects. The Self-Other Orientation Tasks, a combination of various components, enables the researcher to focus on one or more sub-tasks, each scored individually. The present study is focused on the self-esteem component.

The Internal-External Control Scale by Rotter (1966) consists of 29 forced-choice questions including six filler items, resulting in a total possible score of 23. See Appendix B. A biserial item correlation with total score with items removed was given for 200 males and 200 females, and the combined group range was from 0.11 to 0.40 (Rotter, 1966, pp. 11-12). Test data were obtained in a series of samples; some will be cited. In a study conducted at Ohio State University, including 50 male students, split-half reliability of 0.65

was found (Rotter, 1966, p. 13). In another study, in which 50 female Psychology students were given the test, Spearman-Brown reliability was 0.79 (Rotter, 1966, p. 13). It is suggested by Rotter that though the internal consistency estimates are only moderately high, they are relatively stable considering that the items are samples of attitudes in a wide variety of situations. Test-retest reliability (no indication of type of test was given by the author) for one month was 0.60 (administered to 30 male Ohio State University students) and 0.72 for the combined group (30 male Ohio State University students and 30 female Elementary Psychology students). (Rotter, 1966, p. 13). Discriminant validity is indicated by the low relationship with variables such as intelligence. A correlation of -0.11 was found for a combined group of 72 Ohio State University students, who were administered the Internal-External Control Scale and the Ohio State Psychological examination (Rotter, 1966, p. 14). Correlations of the Internal-External Scale with Marlowe-Crowne Social Desirability Scale were obtained in a number of college students samples and ranged between -0.35 and -0.40 for the sixty-item scale and -0.07 and -0.35 for the new scale. It is suggested by Rotter that the greater range may reflect differences in testing conditions (Rotter, 1966, p. 14). Sex differences appear to be minimal; for 575 male students from Ohio State University the mean score was 8.15, SD = 3.88, and for 605 female Elementary Psychology students the mean score was 8.42, SD = 4.06 (Rotter, 1966, p. 15). The score is the total number of the external choices. The median score on the scale was used as the

dividing point for the subjects participating in the present study; those widows scoring at or above the median were referred to as "internals," while those scoring below the median were termed "externals." Internality refers to a person's response to a situation as if controlled by his own behavior. In contrast, externality refers to a person's response to a situation as if controlled by chance, luck, or powerful others. The Internal-External Control Scale was translated into Hebrew by Frankel in 1968 and has been in use for several years. Split-half reliability was 0.71, similar to Rotter's findings (Galatzer, 1975).

The Demographic Questionnaire (Appendix C) was used to obtain general information about the widow as well as information relating to her physical health status and bereavement experience. All information was based upon the widow's subjective report as told to the researcher who conducted the interviews individually. The questions were read to the widows. Questions # 1-12 refer to general information about the respondent (date and place of birth, level of education, number of years married, number of children, number of years of widowhood, and work status). Questions # 13-20 concern the widow's reported physical health status. The psychophysiological aspect of the bereavement process is of primary importance. Parkes (1965, 1975b) found that physical changes occur as a result of a traumatic loss such as a sudden loss of a spouse. Widows experience intense reactions such as fatigue, pain, and insomnia, which may be seen as symptoms. These symptoms often enable the widow to seek the

help of a physician, who prescribes medication, as pointed out by Maddison and Raphael (1972): "Sensation and behavior quite readily categorized as illness exist - pain, tension, suffering, autonomic disturbance, insomnia, fatigue, apathy. The disrupted period of functioning added to this human travail would certainly suggest ground for considering it 'pathological'." (p.787) Schmale (1972) concluded: "Physicians generally tend to treat the symptoms and prescribe medication rather than to relate to the widow's need for help and support in dealing with her grief." (p. 811)

Thus, the changes in physical health as experienced and reported by the widow could act as important criteria of her bereavement process. In the present study information regarding the widow's physical health was related to her reported evaluation of physical health status (no special health problems, few health problems, or many health problems) at present and immediately following the loss; frequency in seeking physician's help (hardly at all, from time to time, or very frequently); use of medication (frequency of use at present and immediately following the loss); type of symptoms (nightmares, insomnia, crying, nervousness, or change in appetite). The physical health score is derived from the sum score of Questions # 13-20; the range of scores is 0-22.

The widow's bereavement experience comes from reports relating to her social functioning following her husband's death and her perception of the social support during that time, as told to the interviewer in response to Questions # 21-26. It is comprised of the

bereaved person's experience and her interpretation of what is expected, permitted, and appropriate during the bereavement process as affected by the reactions and support of the social network at that time. A report was obtained of the widow's personal evaluation of her adaptation as well as of her relationship with her immediate family, her in-laws, and her friends. (Questions #21-26 in the Demographic Questionnaire)

The bereavement adaptation score was derived from the score of Questions # 22, 22a (less change - 0, no change - 1, more change - 2). Question # 24 - widow's evaluation of level of satisfaction (a 4-point scale) and Question # 26 - level of difficulties a widow encounters in various aspect of her life based on her evaluation (a 5-point scale). The purpose of these questions was to evaluate the differences of activities at home, relationships with widow's own family, her in-laws, and her friends immediately following the loss of her spouse and at present.

The last Question (# 27) is the researcher's evaluation of widow's level of resolution of grief based on Ramsy's (1979) differentiation between resolved and unresolved grief. Resolved and unresolved grief are terms indicating the level of "working through" of emotional reactions by the grieving person. Following the shock and disorganization reactions, Ramsy lists searching behavior, desolate pining, despair, guilt, anxiety, jealousy, protest and aggression, and denial as grieving phases. Ramsy says that not all reactions have to be experienced but those present should be expressed

intensely. Avoidance of emotional reactions results in a distorted form of recovery known as "unresolved grief." (Ramsy, 1979, pp. 221-224). According to Averill (1968), grief is the psychological and physiological reaction to a traumatic loss. Although stressful and intense emotionally, it is an important process, known as "grief work," necessary for resolution and acceptance of a new reality which excludes the dead person. Hodge (1972) commented:

> People have a natural tendency to avoid the unpleasantness of the grief work, but it is necessary and the more actively it is done the shorter will be the period of grief. If the grief work is not actively pursued, the process may be fixated or aborted or delayed, with the patient feeling that he may have escaped it. However, almost certainly a distorted form of the grief work will appear at some time in the future. (pp. 230-231)

In the present study information from both parts of the interview, the structured and the unstructured, was used to determine the widow's level of resolution of grief. Resolution was related to the level of intensity of emotions, specifically anger and criticism directed towards self or others and the level of acceptance of the new reality as expressed by the widow. These data were rated on a 1-4 scale (Appendix G).

The examples following the categories were expressed by the widows in Hebrew, and translated into English by the researcher. Expressions of anger, bitterness or criticism:

Score:

1. No expression of anger, bitterness or criticism
Example: "Generally, people want to help even when they say things that hurt. I know they mean well."

2. A minimal expression of anger, bitterness or criticism
Example: "Following the loss I was visited by a woman who was a volunteer. She wasn't really trained. She took a lot of my time and energy but it wasn't very effective."

3. A pronounced expression of anger, bitterness or criticism
Example: "As time passes by things get worse, nobody really understands me. Following the loss, many people came, but now is the time you need them."

4. A strongly pronounced expression of anger, bitterness or criticism
Example: "I am very unhappy since the loss; I feel very bitter. I always think - why me."

Levels of functioning and acceptance of the new reality which exclude the deceased spouse:

Score:

1. A high level of functioning and acceptance of the new reality
Example: "I am different today, more independent. If I met my husband today, I don't think I would marry him."

2. A moderate functioning and acceptance of the new reality
Example: "I am working and doing things at home. It will never be the same, but I have the girls to take care of and that is something."

3. Some difficulties in functioning and acceptance of the new reality
Example: "I go to work only because I have to stop thinking. At home I do nothing; working is an escape."

4. A lot of difficulties in functioning and acceptance of the new reality
Example: "Today's problems are different than those I encountered immediately after the loss. There was more support. I am very lonely, I have many problems with my children and with myself, I feel at a loss.

Resolution of grief:

Score:

1. Resolved grief - no expression of intense negative emotions. The communication of feelings and thoughts that "I know that what happens to me from now on is up to me."

2. Unresolved grief - persistence of intense negative emotions. The communication of feelings and thoughts that "life isn't worth it any longer" and "why did it happen to me?"

For the purpose of determining reliability the interviews were rated by two qualified counselors, who were trained in a procedure similar to that used by Magen (1980). The training procedure included familiarization of the raters with literature by Parkes (1975a,b), Ramsy (1979) and Caplan (1974). The raters read and discussed with the researcher the following subjects: the process of bereavement and grief, resolved and unresolved grief, and the support system. Also, the researcher read to the raters the definitions, categories, and the scales used in the present study.

Data obtained from interviews with 15 widows who were candidates for group counseling led by the interviewer were used to train the raters. They were given the definitions of the categories and the scales, were read excerpts from the interviews, and were trained to use the scales (Appendix G). Fox (1969) considered that 85-90% agreement should be reached in order to be considered sufficiently reliable for use in research. Fox's formula for determining reliability of content analysis was used (p. 670):

$$\text{Percentage of agreement} = 100 \times \frac{\text{Number of units of data coded identically}}{\text{total number of data coded}}$$

Inter-raters agreement on resolved and unresolved grief categories was 93%. It involved 3 categories (Appendix G) used with 15 interviews:

(a) anger and criticism $(\frac{13}{15})$

(b) functioning and acceptance of reality $(\frac{14}{15})$

(c) resolution of grief $(\frac{15}{15})$

Total categories: $100 \times \frac{42}{45} = 93\%$

After obtaining inter-raters reliability following the training, the researcher asked each rater to rate separately the 51 sample interviews. Differences between the raters were resolved by a third rater, a qualified counselor who was trained to rate the interviews in a similar way to the one described. The third rater scored 7 differences in rating category (a), anger and criticism; 4 differences in rating category (b), functioning and acceptance of reality; and 4 differences in rating category (c), resolution of grief.

The Researcher's Questionnaire (Appendix D) consisted of two open-ended questions, each presented on a separate sheet of paper, asking the widows about their helpful and unhelpful experiences with other people. The questions refer to the nature of the experiences, the significant others involved in these experiences, and the intensity of both helpful and unhelpful experiences.

The justification for including these two questions was based on Landsman's conclusion (1968) that the most frequently reported significant experiences are those with other people. Thus the widows were asked only about experiences with others. Caplan (1974) points out that at times of a crisis such as loss of spouse, not only is

support needed but people also have a need to help. If this is the case, then how does the widow perceive this help?

Experiences with others included people from the immediate or extended family, friends, and neighbors. The nature of helpful and unhelpful experiences refers to what people did or did not do which was helpful or unhelpful, what people said and what was perceived by the widow as helpful and unhelpful. Other experiences which are more personal and relate to widow's feelings of loneliness, guilt, or yearning for the deceased husband, were obtained only when the widow wished to share them with the researcher.

The rating included frequencies, intensity, and type of reported helpful and unhelpful experiences. Intensity of helpful and unhelpful experiences as perceived by the widow was rated on a 1-4 scale.

Helpful experiences:
Score:
1 - a mild helpful experience
Example: "It helped to know that I had a family to turn to; it was important for the children."

2 - a helpful experience
Example: "I am lucky to have such a close family who always helped and was ready to do things. My friends are also very helpful and haven't left me."

3 - a very helpful experience
Example: "When you have a family like mine, you have a back to lean on. I had many talks with my brother, who really understood me. I can't tell you how much he helped me."

4 - a most helpful experience
Example: "After it happened [the death of the spouse] a woman came. She was a volunteer, she came every day, she was wonderful, she understood me more than anybody else did. I think I owe her a lot."

Unhelpful experiences:
Scores:
1 - a mild unhelpful experience
Example: "I can't recall any such experience. I guess people do say things which hurt mainly because they are insensitive."

2 - an unhelpful experience
Example: "What was disappointing was that I heard nothing from the army. I expected my husband's friends to be different. It was probably very difficult for them to visit me."

3 - a very unhelpful experience
Example: "My sisters-in-law weren't helpful, they went through bereavement as if it was a party [i.e. the "Shiva," "Shloshim" and twelve months memorial service]. They kept on thinking about money saying - she is lucky he left her money - that hurt a lot."

4 - a most unhelpful experience (Appendix H)
Example: "I will never forgive my in-laws. They didn't want me to stay in the kibbutz with them. They did everything they could so I would leave. They tried to force me to end the pregnancy. I remember all they did to me and it's all because I am not a "wuzwuzit" [Ashkenazi origin].

Types of helpful and unhelpful experiences:

1 - Emotional support (verbal support, understanding, advice, encouragement, discouragement, disapproval, criticism).

A helpful experience:
Example: "She really did nothing special. She listened to me and understood me. It made me feel better."

An unhelpful experience:
Example: "When they told me that time is the best healer, it was very painful and I asked them to leave the house."

2 - Practical-instrumental experiences (active help, financial help, help with the children, avoidance or refusal to help)

A helpful experience:
Example: "I moved to live with my parents; they did everything for me. To this day they do the shopping for me and babysit for the children."

An unhelpful experience:
Example: "I asked my father to babysit for me and he said I could afford a babysitter."

Each interview was rated by two trained raters. The training procedure and the rating procedure was the same as used to rate the researcher's evaluation of resolved and unresolved grief (Question # 27). To familiarize the raters with the subject, the researcher used Landsman's (1968) and Lynch's (1968) research findings on positive experiences and intense human experiences as well as Caplan's (1974) approach to support systems. The raters were given the definitions of the categories and the scales (Appendix H). Inter-raters agreement on both type and intensity of reported helpful and unhelpful experiences, based on Fox's formula (1969, p. 670), was 85%. Four categories were involved:

(a) intensity of helpful experiences $(\frac{10}{15})$

(b) intensity of unhelpful experiences $(\frac{14}{15})$

(c) type of helpful experiences $(\frac{12}{15})$

(d) type of unhelpful experiences $(\frac{15}{15})$

Total categories: $100 \times \frac{51}{60} = 85\%$

Differences between the raters were resolved by a third rater, a qualified counselor, who was trained to rate the interviews on the various categories and scales in a similar way to the one described. The rating included 9 differences in the intensity of helpful experiences and 5 differences in the intensity of unhelpful

experiences; it included 8 differences in the type of helpful experiences and 7 differences in the type of unhelpful experiences.

CHAPTER FOUR
RESULTS

The study investigated patterns of adaptation to bereavement of widows who experienced a sudden loss of their spouses. More specifically, it was the intention of the study to determine whether there exists a relationship between certain personality characteristics and widows' subjective reports of their bereavement experiences.

The sub-scale of self-esteem of the Self-Other Orientation Tasks by Ziller (1973) and Rotter's (1966) Internal-External Control Scale were used to obtain information in regard to personality characteristics (Appendices A, B).

Information regarding widows' bereavement experiences included bereavement adaptation elements: (a) activities at home, (b) relations with their own families, in-laws, friends, and (c) the widows' evaluation of satisfaction and difficulties in regard to various aspects of functioning. Also, information included the widows' report of health status and their experiences with significant others which were perceived as helpful and unhelpful (Appendices C, D). Additionally, the widows' level of resolution was evaluated.

Presentation of the results will include

A. Demographic characteristics of the study's sample population. They are included for purposes of identifying the degree of association they have to the process of bereavement.

B. Self-esteem and Internal-External locus of control and widows' subjective reports of adaptation to bereavement (Research Questions 1 and 2).

C. Personality characteristics of self-esteem and Internal-External locus of control and widows' reports of physical health status (Research Questions 3 and 4).

D. Personality characteristics (self-esteem and Internal-External locus of control) and widows' perceived social support during bereavement; widows' reported helpful and unhelpful experiences (Research Questions 5 and 6).

E. Evaluation of the level of grief resolution as expressed by widows during the interviews.

Demographic Characteristics

The sample included fifty-one widows who experienced a sudden loss of their spouses during war or military activity. Sample selection included a few criteria (see pp.

Table 2

Widows' distribution according to age

Age	24-30	31-40	41-50
% frequency	16% (8)[a]	59% (30)	25% (13)

[a] Number in parentheses indicates number of widows responding (n = 51).

The age group 31-40 years is the largest and, when combined with the age group 24-30 years, it can be seen that the majority of widows were quite young when their husbands died. (Table 2)

Table 3

Widows' distribution according to country of birth

Place of birth	Israel	Europe N. America	Asia Africa
% frequency	51 (26)[a]	20 (10)	29 (15)

[a] Number in parentheses indicate numbers of widows responding ($\underline{n}$ = 51).

The total number of widows born in Europe, U.S.A., Canada, Asia, and Africa is similar to the number of those born in Israel (Table 3).

The terms "Sephardi" and "Ashkenazi" refer to the ethnic origin of immigrants from different parts of the world. Israelis of "Sephardi" origin include all immigrants from Asia and Africa and those born in Israel to families originating from one of these continents. Israelis of "Ashkenazi" origin are those who arrived from Europe or North America or were born to families from those areas. The differences between these two ethnic groups involve not only cultural ones as they existed in the countries of origin (Islam vs. Christianity, oriental vs. western countries, or "traditional" vs. "modern" orientation) but also differences in Jewish religious

practices which include different life styles, education, and, especially pertinent to the present study, different mourning customs.

The Israeli attitude of the "melting pot" included the idea of the emergence of a "Sabra" (Israeli-born) as the "product" of a Western-oriented Israeli society. This new society deemphasizes ethnic customs. The social result is a blend of many elements such as ethnic origin, level of education, and level of income.

Table 4

Widows' distribution according to religious affiliation

Religious affiliation	Religious	Traditional	Secular
% Frequency	6 (3)[a]	27 (14)	67 (34)

[a] Number in parentheses indicates number of widows responding (n = 51).

Different ethnic groups practise different mourning rituals and customs (Palgi, 1973). As can be seen in Table 4, 67% of the widows interviewed identified themselves as "Hiloni" (secular); being more liberal in their religious affiliation, they practise mourning rituals in a very limited way. The 27% who identified themselves as "Mesorti" (traditional) and the 6% who identified themselves as "Dati" (religious) more extensively observe the Jewish religion, including mourning rituals and customs.

The average number of years of marriage of the sample population was 9.5 and the average number of years of widowhood was 6.5. In the

sample, 36 were widowed during the October war (1973) and the other 15 were widowed from two to five years. The mean number of children per widow was 2.5 (range 1-5).

Table 5

Work status of widow before and after loss of spouse expressed as a %

	Work Status			
	Home	Study	Part-time employed	Full-time employed
Before	24	0	6	70
After	27	16	16	41

There was a noticable difference between the widow's work status prior to and following the loss of the spouse (Table 5). Whereas 30 widows (70%) were holding full-time jobs prior to the loss as compared to 12 widows (24%) who were at home, only 21 widows (41%) kept full-time jobs following the loss of their spouses.

Most of the widows in the sample were between 24-40 years old, were married 9.5 years, and had been widowed 8 years. Also 62% of the group had 2 or 3 children at the time of the interview.

Personality Variables and Adaptation to Bereavement.

Research Question 1: What is the relationship between the level of self-esteem and widows' reported bereavement adaptation? (Questions 21-26 in the Demographic Questionnaire).

Widows' reported bereavement adaptation score consisted of (a) the sum score of Questions 21,22,22a in the Demographic Questionnaire (Appendix C), (b) the widow's evaluation of satisfaction from her relationship with the children, friends etc. (Question 24 in the Demographic Questionnaire), and (c) level of difficulty that the widow experienced with various aspects of her life (Question 26 in the Demographic Questionnaire).

Frequencies of the categories of the various elements as they appear in Questions 21,22,22a are shown in Table 6.

Activities at home: Question 21 in the Demographic Questionnaire (Appendix C) included the following: "Any changes in your activities?" The replies were categorized as "no change," "less active than before," and "more active than before."

The frequencies shown in Table 6 reveal that 56% of the widows with low self-esteem reported "less than before" as compared to 27% with high self-esteem. The most frequently reported category among widows with high self-esteem was "no change in homekeeping activities" (54%) in contrast to 20% of widows with low self-esteem. These differences were significant ($p < .05$). The category "more activities than before" was similarly reported by widows of both groups (24% vs. 19%).

Relationship with widow's own family: Question 22 included changes in social activities (relationships with family and in-laws). Because widows specified their relationships with their in-laws in addition to

those with their own families, relationships with in-laws are reported separately (see Table 6). No significantly different response frequencies were found between the two groups of widows categorized by self-esteem.

Relationship with in-laws: There were no significant differences between high and low self-esteem widows in regard to the relationship with in-laws (see Table 6).

Relationship with friends: Question 22a in the Demographic Questionnaire related to widows relationship with friends. More high self-esteem widows reported their relationship with friends to be "more than before " (50% vs. 28%) but the differences were not significant (Table 6).

Widow's evaluation of level of satisfaction (Question 24 in the Demographic Questionnaire, Appendix C) was measured on a 4-point scale from "not at all satisfied" (1) to "very satisfied" (4). The widow's evaluation of her level of satisfaction was generally phrased: "Are you satisfied in general with yourself and in the way you handle problems?" The widows were asked to evaluate their satisfaction as accurately as possible. The mean value for the total sample was $\underline{x} = 2.56$, $\underline{SD} = .87$.

Table 6

Frequency of widows' reported changes in activities at home and with others in relation to self-esteem personality variable (Demographic Questionnaire questions 21, 22, 22a)

Self-esteem	% Frequency of Reported Changes											
	Activities at home			Relationship with widow's family			Relationship with in-laws			Relationship with friends		
	0[a]	1	2	0	1	2	0	1	2	0	1	2
Low $n = 25$	56 (14)[b]	20 (5)	24 (6)	4 (1)	40 (10)	56 (14)	48 (12)	8 (2)	44 (11)	64 (16)	8 (2)	28 (7)
High $n = 26$	27 (7)	54 (14)	19 (5)	8 (2)	19 (5)	73 (19)	31 (8)	15 (4)	54 (14)	38 (10)	12 (3)	50 (13)
x^2 =		6.67			2.74			1.80			3.36	
df =		2			2			2			2	
p <		.05			ns			ns			ns	

[a] 0 = less than before, 1 = no change, 2 = more than before

[b] number in parentheses indicates number of widows responding

The results of the frequency and its relationship to self-esteem are shown in Table 7.

Table 7

Frequency of level of satisfaction expressed by widows in relation to self-esteem personality variable

Self-esteem variable	% Frequency reported level of satisfaction			
	1	2	3	4
Low $n = 25$	24 (6)[a]	36 (9)	32 (8)	8 (2)
High $n = 26$	8 (2)	8 (2)	73 (19)	11 (3)

$X^2 = 11.12$
$df = 3$
$p < .01$

[a] Number in parentheses indicates number of widows responding.

For widows with low self-esteem, the frequencies of responses were distributed fairly evenly among levels 1 (not at all satisfied), 2 (partly satisfied), and 3 (satisfied). In contrast, widows with high self-esteem most frequently reported level 3. The difference between the high and low self-esteem groups was significant ($p < .01$).

Pearson's correlation coefficient was applied to test for significant relationship between the self-esteem variable and the elements comprising bereavement adaptation score. The results are presented in Table 8.

Table 8

Relationship between self-esteem and bereavement adaptation elements (Questions 21,22,22a,24,26 in the Demographic Questionnaire)

Self-esteem - Bereavement Adaptation Elements	Statistic r
Activities at home	.16
Relationship with widow's family	.11
Relationship with in-laws	.15
Relationship with friends	.26*
Level of satisfaction	.37***
Difficulties with children	-.22
Difficulties with widow's own family	.04
Difficulties with in-laws	.03
Difficulties with finances	-.30*
Difficulties with old friends	-.20
Loneliness	-.05
Difficulties with new friends	-.35**
Health	-.24*
Going out to work	-.29*

* $p < .05$
** $p < .01$
*** $p < .005$

Self-esteem was found to be only partially related to bereavement adaptation (Table 8) . Elements found to be significantly related to self-esteem were (a) widows' relationships with friends ($r=.26$, $p < .05$), (b) level of satisfaction ($r=.37$, $p < .005$), difficulties with finances ($r=-.30$, $p < .01$, indicating a negative correlation, i.e. the lower the self-esteem the more financial difficulties the widow encounters), (d) health ($r=-.24$, $p < .05$, negative correlation), (e) going out to work ($r=-.29$, $p < .05$, i.e. the greater the difficulties in going out to work, the lower was the level of widow's self-esteem), and (f) difficulties with new friends ($r=-.35$, $p< .01$).

Responses to a set of questions from the Demographic Questionnaire were analyzed in order to determine the relationship between self-esteem and widows' reported bereavement adaptation.

The results show that a relationship exists between self-esteem and the following elements of bereavement adaptation: relations with friends, financial difficulties, and level of satisfaction. There was also a significant difference between the groups in regard to the "activities at home" element. Differences between the groups concerning other elements were not significant; in fact, other elements were reported equally by high and low self-esteem widows.

Research Question 2: What is the relationship between the internal versus external locus of control and the widows' reported bereavement adaptation?

The median internal locus of control score for the research sample was 13. Those widows scoring below the median were referred to as "externals" and those scoring at or above as "internals" (26 and 25 respectively). The mean "external" score was 10.75 and mean internal score 12.35. The frequency of external and internal locus of control and widows' reported bereavement adaptation elements are presented in Table 9.

Activities at home: No differences in response were found between "internal" and "external" widows.

Relationship with widow's own family: Changes in relationship with widow's own family were significantly different ($p < .05$) at the 0 (less than before) and 1 (no change) levels.

Relationship with in-laws: No significant differences in relationship with in-laws were observed between the groups.

Relationship with friends: There was a noticeable difference ($p < .05$) between "external" and "internal" widows in their responses to change in relationships with friends at the 0 (less than before) and 2 (more than before) levels (69% vs. 32% and 23% vs. 56% respectively).

Widow's evaluation of level of satisfaction (Question 24 in the Demographic Questionnaire) was measured on a 4-point scale ranging from "not at all" (1) to "very satisfied" (4). The mean level of satisfaction for the sample was: $\underline{x} = 2.56$, $SD = .87$, $N = 51$. The frequency and relationship of "internal" vs. "external" widows and evaluation of level of satisfaction are summarised in Table 10.

No differences were found at any of the levels between the two groups of widows.

Pearson's correlation coefficient was applied to test for significant relationship between the personality variable internal-external locus of control and bereavement adaptation score. The results are presented in Table 11.

Table 9

Frequency of widows' reported changes in activities at home and with others in relations to internal-external locus of control personality variable (Demographic Questionnaire questions 21,22,22a)

Locus of control	% Frequency of Reported Changes											
	Activities at home			Relationship with widow's family			Relationship with in-laws			Relationship with friends		
	0[a]	1	2	0	1	2	0	1	2	0	1	2
External $n = 26$	42 (11)[b]	42 (11)	16 (4)	0 -	42 (11)	58 (15)	39 (10)	15 (4)	46 (12)	69 (18)	8 (2)	23 (6)
Internal $n = 25$	40 (10)	32 (8)	28 (7)	12 (3)	16 (4)	72 (18)	40 (10)	8 (2)	52 (13)	32 (8)	12 (3)	56 (14)
x^2 =		1.32			6.52			.68			7.22	
df =		2			2			2			2	
p		n.s.			$< .05$			ns			$< .05$	

Footnotes as in Table 6.

Table 10

Frequency of widow's reported level of satisfaction in relation to External-Internal locus of control personality variable

	% Frequency of widows response			
Locus of control	1[a]	2	3	4
External $\underline{n}$ = 26	12 (3)	31 (8)	54 (14)	3 (1)
Internal $\underline{n}$ = 25	20 (5)	12 (3)	52 (13)	16 (4)

X^2 = 4.59
df = 2

[a] Level of satisfaction

Table 11

Relationship between internal-external locus of control and bereavement adaptation elements (Questions 21,22,22a,24,26 in the Demographic Questionnaire)

Internal-External locus of control - Bereavement Adaptation elements	Statistic $\underline{r}$
Activities at home	.05
Relationship with widow's family	.12
Relationship with in-laws	.04
Relationship with friends	.37**
Level of satisfaction	.20
Difficulties with children	-.11
Difficulties with widow's own family	.06
Difficulties with in-laws	.14
Difficulties with finances	-.24*
Difficulties with old friends	-.28*
Loneliness	-.01
Difficulties with new friends	-.04
Health	-.01
Going out to work	-.10

* $\underline{p} < .05$
** $\underline{p} < .005$

The internal-external locus of control was used as an independent variable to establish whether a relationship exists between certain personality characteristics and widows' reported bereavement adaptation. A significant difference between "external" and "internal" groups was found to be associated with the elements "relationship with widow's own family" and "relationship with friends."

The elements "relationship with friends," "difficulties with finances," and "difficulties with old friends" were significantly related to the personality variable internal-external locus of control.

Personality Variables and Reported Health Status

Research Question 3: Do "high and low" self-esteem widows differ in their reported physical health status?

Widows' reported physical health status was the sum score of questions 13-20 in the Demographic Questionnaire (Appendix C); each "yes" scored 1 point (ranging from 0 to 22). A low score indicates few health problems whereas a high score indicates many health problems. Means of self-esteem for the total sample, high and low self-esteem and widows' reported physical health score are presented in Table 12.

The mean of widows' reported health score, 5.86 for the total sample population, indicated few health problems. There was however a significant difference ($p < .05$) between sample means of high and low self-esteem groups and widows' reported health status score (Table

12). This result indicated that there were more reported health problems among widows with low self-esteem($\bar{X}$ = 7.40) than among widows with high self-esteem ($\bar{X}$ = 4.38).

Table 12

t-test between sample means of high self-esteem and low self-esteem and widows' reported physical health score

Variables	n	$\bar{X}$	SD	t	df
Self-esteem					
Low	25	19.72	3.43		
High	26	29.03	3.63		
Total	51	24.47	5.87		
Reported physical health status					
Low	25	7.40	4.73		
High	26	4.38	4.79	2.25*	48
Total	51	5.86	4.97		

* $p < .05$

Research Question 4: Do "internal and external locus of control" widows differ in their reported physical health status?

The scoring of widows' reported health status was applied as in question 3, and was based on the sum score of questions 13-20 in the Demographic Questionnaire (Appendix C). The means of widows' reported health status appears in Table 13.

The median locus of control score for the research sample was 13. This score was the dividing point between "internal" and "external" widows.

A t-test for the means of "external" and "internal" groups to test for significant differences is presented in Table 13.

Table 13

t-test between sample means of "external" and "internal" groups and widows' reported physical health score

Variables	n	$\bar{x}$	SD	t	df
I-E locus of control					
External	26	10.38	1.70		
Internal	25	14.76	2.16		
Total	51	12.35	3.06		
Reported physical health score					
External	26	5.27	4.06		
Internal	25	6.48	5.79	-.87*	42
Total	51	5.86	4.97		

*p = n.s.

There are no differences in regard to reported health status of "external" and "internal" widows (Table 13). The mean score of reported health status score was found to be higher for "internal" than for "external" widows (6.48 and 5.26, respectively).

The dimension of health in bereavement adaptation was examined in its relationship to the widow's level of self-esteem and internal-external locus of control.

There was a statistically significant difference in the reported health status score between high and low self-esteem widows but not between "external" and "internal" widows.

Personality Variables and Reported Experiences

Research Question 5: Is there a relationship between widows' level of self-esteem and the frequency, intensity, and type of their reported helpful and unhelpful experiences?

Two open-ended questions comprising the Researcher's Questionnaire (Appendix D) were used to obtain information about widows' reported helpful and unhelpful experiences with significant others. The data collected were rated by two trained raters (see pp. 53-57 for details).

Frequencies of widows' reports of the type of helpful and unhelpful experiences and their relationship to level of self-esteem are presented in Table 14.

The results presented in Table 14 reveal that helpful experiences of the instrumental type was reported by 72% of low self-esteem widows and 31% of the high self-esteem group. Helpful experiences of the affective type were reported by 28% of the widows with low self-esteem and by 69% of widows with high self-esteem. The differences were significant ($p < .01$).

The intensity of the widows' reports of helpful and unhelpful experiences was rated on a 4-point scale. See Appendix H for the

Table 14

Frequency and number of self-esteem widows reporting type of helpful and unhelpful experiences

Self-Esteem	% Frequency of Helpful experiences Instrumental=1	Affective=2	Unhelpful experiences Instrumental=1	Affective=2
Low	72	28	32	68
$n = 25$	(18)	(7)	(8)	(17)
High	31	69	23	77
$n = 26$	(8)	(18)	(6)	(20)
χ^2 =	7.10		1.59	
df =	1		1	
p <	.01		ns	

Table 15
Frequency of self-esteem widows reporting helpful or unhelpful experiences

Self-esteem	% Frequency of Helpful experiences[a] 1	2	3	4	Unhelpful experiences 1	2	3	4
Low	20	40	20	20	4	8	20	68
$n = 25$ $\bar{x} = 19.72$	(5)[b]	(10)	(5)	(5)	(1)	(2)	(5)	(17)
High	8	12	42	38	15	31	19	35
$n = 26$ $\bar{x} = 29.03$	(2)	(3)	(11)	(10)	(4)	(8)	(5)	(9)
χ^2 =	8.96				7.85			
df =	3				3			
p <	.05				.05			

a Intensity of experience measured on a 4-point scale from mild (1) to most intense (4).

b Number in parentheses indicates number of widows responding.

categories of reported helpful and unhelpful experiences. The relationship between the rated intensity and the level of self-esteem is presented in Table 15.

Table 15 shows that helpful experiences of greater intensity (level 3 and 4 together) were reported more frequently by high than by low self-esteem widows (80% vs. 40%; $p < .05$). The results of the intensity of unhelpful experiences show that the most intensely unhelpful experiences (levels 3 and 4 together) were reported by 88% of low vs. 54% of high self-esteem widows ($p < .05$). Although the most intensely unhelpful experiences were more frequently reported by low self-esteem widows, it is of interest to note that intensely unhelpful experiences were frequently reported by both groups.

Pearson's correlation coefficient was applied in order to test for significant relationship between widows' level of self-esteem and the type and intensity of the reported helpful and unhelpful experiences; the results are shown in Table 16.

Table 16

Self-esteem and widows' reported type and intensity of helpful and unhelpful experiences

Reported experience	Statistic r
Type of helpful experiences	.41**
Type of unhelpful experiences	.10
Intensity of helpful experiences	.35*
Intensity of unhelpful experiences	-.38**

* $p < .01$
** $p < .005$

Widows' level of self-esteem was found to be related to both the type and intensity of their reported helpful experiences. There was a negative correlation between intensity of unhelpful experience and level of self-esteem, i.e. the lower the level of self-esteem, the more intense was the unhelpful experience (Table 16).

Widows' level of self-esteem was found to be significantly related to the type of helpful experiences and to the intensity of their reported helpful and unhelpful experiences.

Widows with low self-esteem more frequently reported experiences of the instrumental type, whereas widows with high self-esteem more frequently reported experiences of the affective type. All widows more frequently reported unhelpful experiences of the affective type than of the instrumental type.

Research Question 6: Is there a relationship between widows' internal vs. external locus of control and the intensity and type of their reported helpful and unhelpful experiences?

Widows' reports of the type of their helpful and unhelpful experiences were obtained from their responses to the Researcher's Questionnaire (Appendix D) and were rated by two trained raters.

The results of widows' reports of the type of their helpful and unhelpful experiences and their relationship to internal-external locus of control are presented in Table 17. No significant differences between the two groups of widows were recorded.

Table 17

Frequency of widows' reported type of helpful and unhelpful experiences in relation to locus of control

Locus of Control	% Frequency of Helpful experiences Instrumental=1	Affective=2	Unhelpful experiences Instrumental=1	Affective=2
Externals $n = 26$ $\bar{x} = 10.75$	58 (15)	42 (11)	27 (7)	73 (19)
Internals $n = 25$ $\bar{x} = 12.35$	44 (11)	56 (14)	28 (7)	72 (18)
χ^2 =	.487		0	
df =	1		1	

Table 18

Frequency of intensity of widows' reported helpful and unhelpful experiences in relation to locus of control

Self-esteem	% Frequency of reported Helpful experiences[a] 1	2	3	4	Unhelpful experiences 1	2	3	4
Externals $n = 26$ $\bar{x} = 10.75$	15 (4)	31 (8)	35 (9)	19 (5)	8 (2)	15 (4)	19 (5)	58 (15)
Internals $n = 25$ $\bar{x} = 12.35$	12 (3)	20 (5)	28 (7)	40 (10)	12 (3)	24 (6)	20 (5)	44 (11)
χ^2 =		2.73				1.19		
df =		3				3		

[a] Experience measured on a 4-point scale from mild (1) to very intense (4).

The intensity of widows' reported helpful and unhelpful experiences were rated on a 4-point scale; the results are presented in Table 18. In general, reported unhelpful experiences were more intense than helpful experiences throughout the sample population.

There was no difference between "external" and "internal" widows regarding intensity of reported helpful and unhelpful experiences (Table 18).

Pearson's correlation coefficient was applied in order to test for significant relationship between "internal" vs. "external" widows and the intensity of their reported helpful and unhelpful experiences (Table 19). There is no reliable relationship between the paired variables.

Table 19

"External" vs. "internal" locus of control and type and intensity of widows' reported helpful and unhelpful experiences

Reported experiences	Statistic r
Type of helpful experiences	-.01
Type of unhelpful experiences	-.04
Intensity of helpful experiences	.19
Intensity of unhelpful experiences	-.15

There was no relationship between the personality variable of internal-external locus of control and the widows' reported experiences.

Resolution of Grief

The evaluation of grief resolution, based on the widows' subjective reports as expressed during the interviews, explored the relationship between grief resolution and personality characteristics (self-esteem and internal-external locus of control).

Question 27 in the Demographic Questionnaire (Appendix C) was the researcher's evaluation of the widow's level of resolution of grief. This evaluation was based on information obtained from both parts of the interview, the unstructured and the structured, and was rated according to the categories (Appendix G) by two independent raters (see pp. 50-51 for training and rating procedure). The correlation coefficient between the researcher's and raters' evaluations was found to be .66 ($p < .001$).

Pearson's correlation coefficient was applied in order to test for significant relationships between rater's evaluation of the various categories of resolution of grief and the personality variables of self-esteem and internal-external locus of control. The results are shown in Table 20.

As can be seen in Table 20, the level of grief resolution as evaluated by the raters was found to be significantly related to the personality variable of self-esteem but not to the internal-external locus of control.

Table 20

Relationship between the personality variable locus of control and self-esteem and raters' evaluation of grief resolution categories

Category of grief resolution	Locus of control r	Personality variable self-esteem r
Anger and criticism	.00	-.33*
Level of acceptance of new reality	.16	-.50**
Level of resolution of grief	-.19	.46**

* $p < .01$ ** $p < .002$

Finally, a factor analysis was applied to identify the variables involved in the process of bereavement adaptation that can best explain the various dimensions of its outcome. A principal component factor analysis using unities in the diagonal was applied.

The factor loadings for each element is shown in Table 21. The three main factors were (1) bereavement adaptation - the self and others experience, (2) relationship with in-laws, and (3) bereavement adaptation - the health dimension.

As can be seen from Table 21, level of difficulties with children (item 13), intensity of helpful experiences (item 22), and raters' evaluation of level of reality acceptance (item 25) had high loading on two factors. The three factors accounted for 67.1% of the variance.

Table 21

Factor loadings for bereavement adaptation items*
following principal component factor analysis with varimax rotation

Items	Factors I	II	III
1. Place of birth	.09	.17	.06
2. Number of children	-.13	.05	.05
3. Level of education	.20	-.21	.03
4. Work status	.05	-.05	-.04
5. Studying	.13	-.13	.04
6. Health status core	-.20	.25	.83
7. Changes in functioning at home	.23	-.20	.07
8. Changes in relationship with widows' family	.24	-.14	-.55
9. Changes in relationship with in-laws	.22	-.51	-.05
10. Changes in relationship with friends	.61	-.16	-.20
11. Level of satisfaction	.75	-.26	-.04
12. Religious affiliation	-.04	.08	.02
13. Level of difficulties with children	-.50	.49	.16
14. Level of difficulties with widows' own family	-.00	.08	.05
15. Level of difficulties with in-laws	-.07	.29	-.05
16. Level of difficulties with finances	-.19	.11	.18
17. Level of difficulties with old friends	-.22	.07	.15
18. Loneliness	-.23	.03	.06
19. Level of difficulties with new friends	-.58	.03	.13
20. Level of health difficulties	-.13	.10	.80
21. Level of difficulties in going out to work	-.21	.24	.42
22. Intensity of helpful experiences	.54	-.41	-.12
23. Intensity of unhelpful experiences	-.26	.83	.26
24. Raters' evaluation of level of anger criticism	-.35	.66	.34
25. Raters' evaluation of level of reality acceptance	-.66	.47	.32
26. Self-esteem	.40	-.06	.34
27. Internal-External locus of control	.42	-.09	.15
Eigenvalue	7.63	2.24	1.82

* Only nominal and interval type of items were included.

Table 22

Factor assignment of bereavement adaptation items by highest factor loading

Items		Loading
Factor I Bereavement Adaptation - the self and others experience		
10.	Changes in relationship with friends	.61
11.	Level of satisfaction	.75
13.	Level of difficulties with children	-.50
19.	Level of difficulties with new friends	-.58
22.	Intensity of helpful experiences	.54
25.	Raters' evaluation of level of functioning a reality acceptance	-.66
26.	Self-esteem	.40
27.	Internal-External locus of control	.42
Factor II Relationship with In-Laws		
9.	Changes in relationship with in-laws	-.51
13.	Level of difficulties with children	.49
22.	Intensity of helpful experiences	-.41
23.	Intensity of unhelpful experiences	.83
24.	Raters' evaluation of anger and criticism	.66
25.	Rater's evaluation of level of functioning a reality acceptance	.47.
Factor III Bereavement adaptation - the health dimension		
6.	Health status score	.83
8.	Changes in relationship with widow's own family	-.55
20.	Level of health difficulties	.80
21.	Level of difficulties in going out to work	.42

Table 22 groups the items of bereavement adaptation by highest factor loading, the loading of the items on the factor. The cut-off point was .40. The largest number of items load on factor I, bereavement adaptation - the self and others experience. Also, factor I has the largest Eigenvalue.

Factor I reflects the interaction between the self and the social environment as perceived by widows during the process of bereavement. As can be seen, some items correlate positively with the underlying factor whereas others correlate negatively. The items in Factor I are comprised of those which were based on the widow's own evaluation of her experience (items 10,11,13, and 19), the raters' evaluation of the reported experiences (items 22 and 25) and the widow's own self-esteem and locus of control (items 26 and 27). The items - level of difficulties with children (13), with new friends (19), and the raters' evaluation of level of functioning and acceptance of reality (25) - correlate negatively with the factor. For these items a low score indicates fewer difficulties than does a high score.

Factor II represents the items of changes in relationship with in-laws, level of difficulties with children (based on widow's own evaluation), intensity of both helpful and unhelpful experiences, level of anger and criticism, and level of reality acceptance (based on raters' evaluation). Level of difficulties with children, which correlates positively with the underlying Factor, loads high also on Factor I. The same is true with intensity of helpful experiences (22) and raters' evaluation of level of reality acceptance (25); these items also load high on Factor I but the direction of the correlation with the underlying Factor is different. Changes in relation with in-laws (9), which is negatively correlated with the factor, is associated with a deterioration in the relationship with in-laws. The

intensity of helpful experiences, which also correlates negatively with the factor, indicates a lower level of intensity of helpful experiences.

Factor III, health and adaptation to bereavement, reflects the significance of the item of health during the process of bereavement combined with items 8 and 21 (changes in relations with widow's own family and difficulties in going out to work). It is important to note that both items relating to health are grouped in the Factor - the score of health status (6) and widow's evaluation of level of health difficulties (20).

The two items complement each other. The score of health status was the sum score of questions 14-20 in the Demographic Questionnaire (Appendix C), which included information about health problems, referral to the widow's physician, and the occurrence of various symptoms. The item, level of difficulties, focused generally on the widow's evaluation of her health. The health items which correlate positively with the Factor, indicate that a higher score is associated with more health problems. Changes in relations with the widow's own family (item 8), which is negatively correlated with the Factor, and level of difficulties in going out to work (item 21) indicate the interrelationship between these items during the process of adaptation to bereavement.

CHAPTER FIVE
DISCUSSION

The focus of the study was the relationship between personality characteristics and bereavement adaptation following a sudden loss of a spouse. For the study, fifty-one widows were individually interviewed. Six research questions were designed to examine the relationships between the personality variables - self-esteem and internal-external locus of control - and various dimensions of bereavement adaptation as reported by the widows.

The researcher, who worked with bereaved families during the October War 1973 and subsequently counseled groups of war widows, observed a wide range of bereavement adaptation and outcomes. The present study was therefore designed to analyze factors that influence the bereavement of war widows.

The study is based upon certain assumptions. Grief is a normal reaction to a traumatic loss, and bereavement is a natural process with predictable stages and psychophysiological reactions. Bereavement is a complex process, in which bereaved persons gradually adapt to a new reality, rebuild their identities, and redefine their roles. Furthermore, the bereavement process and its outcome are influenced both by individual differences and by the response of the social support system. (Parkes, 1970; Caplan, 1974; Ramsy, 1979)

The study focuses upon a specific group of bereaved persons -- women whose husbands died suddenly in war or during military service.

One characteristic that distinguishes this group is the fact that all experienced a sudden loss. As Parkes (1970) has pointed out, a sudden loss brings more difficulties, particularly in the beginning, than does an expected loss. Another distinguishing characteristic is that all the bereaved had been married women. The loss of a spouse signficantly affects self-esteem. As Lopata (1973, 1975) and Silverman (1975) have indicated, the self-esteem of a married person is strongly influenced by the attitude of the spouse. As a result, the death of a spouse, especially in a Western couple-oriented society, alters a person's self-esteem. In addition, the death of a husband, unlike the death of another significant other, alters the woman's social role. No longer a wife, the woman perceives herself differently and is also perceived differently by society.

In this study a phenomenlogical approach focused on the widows' subjective experience as reported during individual interviews. The interviews, each lasting from 1.5 to 2 hours, consisted of an initial unstructured part for the purpose of establishing rapport and of a structured part for the administration of a series of questionnaires. Two questionnaires -- Ziller's (1973) sub-scale of self-esteem of the Self-Other Orientation Tasks and Rotter's (1966) Internal-External Control Scale -- were used to obtain information regarding personality characteristics. Two other questionnaires -- the Demographic Questionnaire and the Researcher's Questionnaire -- were used to obtain information regarding bereavement adaptation and resolution of grief. On these questionnaires the widows reported their activities at home and with others, their physical health, and their helpful and

unhelpful experiences with significant others; in addition the researcher evaluated the resolution of grief. (Appendices A, B, C, and D)

Self-esteem and Bereavement

The study explores the relationship between the personality variable of self-esteem and bereavement dimensions (Research Questions 1, 3, 5). Self-esteem was used in the present study because of its emphasis upon the self-social system (Ziller, 1973), an emphasis in accordance with the approach postulated by Caplan (1974) regarding crisis theory and the support system. In addition, Ziller's self-other Orientation Tasks, based on a phenomenological orientation, stress the individual's point of view within the social context.

A relationship was demonstrated between self-esteem and some elements of the widows' reported bereavement adaptation, their reported health status, and reported experiences with significant others. A significant difference between high and low self-esteem widows was found regarding the elements "activities at home" ($\underline{x}^2$=6.70(2), $\underline{p} < .05$) and widow's own evaluation of level of satisfaction ($\underline{x}^2$=11.12(3), $\underline{p} < .01$). The elements of relationship with friends ($\underline{r}$=.26, $\underline{p} < .05$) widows' evaluation of level of satisfaction ($\underline{r}$=.37, $\underline{p} < .005$), difficulties with finances ($\underline{r}$=-.30, $\underline{p} < .05$) difficulties with new friends ($\underline{r}$=-.35, $\underline{p} < .01$) and going out to work ($\underline{r}$=-.29, $\underline{p} < .05$) were found to correlate with the widows' level of self-esteem (Tables 6, 8).

Other elements were not statistically significant. This lack of correlation may indicate that there is no relationship between them

and the personality variable of self-esteem. However, it may instead result from the construction of the questions in the Demographic Questionnaire. Since these questions were phrased to obtain factual information rather than a detailed account of the specific elements, some important data were not included. Alternatively, the statistical analysis (Pearson correlation coefficient) assumed a linear relationship between the personality variable and the various elements.

Bereavement elements found to be statistically related to self-esteem occurred on both the personal and interpersonal levels. Relationship with friends, difficulties with new friends, and difficulties in going out to work clearly represent the interpersonal level, whereas widow's evaluation of level of satisfaction with activities at home and difficulties with finances can be seen as occurring on a more personal level. However, although difficulties with finances occur on the personal level in so far as they reflect the widow's emotional state, the financial difficulties also involve the interpersonal level because others view them as practical difficulties.

Financial assistance to widows who lose their spouses through a war or on military service in Israel is the state's responsibility; the widows are eligible for a comprehensive monthly allowance regardless of their financial status. It is therefore suggested that the widows' reported financial difficulties, which were found to be associated with a lower level of self-esteem, are not necessarily an indication of an objective state but rather an expression of the

widows' internal frame of reference.

Widows with high self-esteem indicated more relationships with friends, fewer difficulties in relationships with new friends, and fewer difficulties in going out to work than did widows with low self-esteem. One possible explanation is that widows with high self-esteem are more socially supported; another is that they are more able to generate social support. In accord with Ziller's (1974) findings the level of self-esteem and level of support are clearly involved.

Amir & Sharon (1979), in their study on war widows and factors in adjustment to the loss, included women who became widowed during two different wars. According to the researchers, women who became widowed prior to the State's introduction of its economic assistance policy to bereaved families had financial problems related to their adjustment to the loss. And women who became widowed during the October War, 1973, (with the economic aid scheme already in operation) had difficulties in adjustment to the loss related to social-emotional problems. Amir & Sharon concluded that differences in adjustment to the loss between the two groups can be explained on the grounds of differences in the economic-financial policy. When financial problems are cared for, widows' difficulties are not economic but rather social-emotional. These findings were, according to the researchers, analogous to Maslow's (1954) hierarchy of needs.

Harvey & Bahr (1974) stressed that the economic variable is of major importance in widows' adjustment to the loss. In their opinion,

lack of financial resources greatly influences widows' level of functioning and thus their bereavement outcomes. A different viewpoint is offered by Ben Sira (1976, 1980), who concluded that delivery of instrumental support is insufficient if not accompanied by emotional support. The present findings of widows' reported financial difficulties support Ben Sira's conclusion. The financial difficulties reported by the widows may indicate emotional, rather than financial, distress; however, those within the social support system respond to these complaints only on a financial level.

The widows' evaluation of satisfaction provides valuable information about their adaptation to the loss. The evaluations, although subjective, accurately report the widows' own estimation of themselves. High self-esteem widows more frequently reported a higher level of satisfaction then did widows with low self-esteem (Table 7). According to Ziller (1974), the personality construct of self-esteem emphasizes self-others interaction. The self is seen in its social context. Moreover, there is a cyclical process whereby low self-esteem reinforces reduction in social support, which then results in reduced self-esteem. The converse applies to high self-esteem individuals, who generate social support that results in increased self-esteem. It is also possible that high, as opposed to low, self-esteem individuals can create a more supportive environment through their ability to evoke such support from others. At any rate, the interaction between the two is clear, especially in regard to traumatic events such as a sudden loss of a spouse. A loss of a

spouse is seen also as a critical social event and as such requires considerable social support resources. Since at times of crisis the role of the social network is emphasized (Caplan, 1974, Silverman, 1975), such involvement between self-esteem and social environment as seen by the widows is of special importance. When support is perceived as unhelpful, it has more effect upon widows with low self-esteem than upon those with high self-esteem.

Self-esteem and the dimension of health as expressed by widows' reported physical health status: A t-test for differences between the group means was applied and the difference was found to be significant (t=2.25(48), $p < .05$) (Table 12). The dimension of health was included because grief involves psychophysiological reactions. Loss of appetite, pain, tension, fatigue, and insomnia have been identified to occur following a traumatic loss such as the death of a spouse. These reactions are normal, and almost all bereaved people experience them. Pain and suffering are so intense that there is a normal tendency to avoid these psychophysiological reactions. This avoidance is reinforced by the social network, which sees the reduction of pain and suffering as appropriate help for the bereaved. To alleviate symptoms such as fatigue, insomnia, and pain, the physician commonly prescribes medication (Maddison & Raphael, 1972; Parkes, 1975a,b).

Maddison and Raphael (1972) have cautioned against the widespread use of medication during grief not only because of its effects on the grieving persons but also because of its social implications:

> It is possible that such attitudes can lead to an addictive society and in the current climate of widespread drug abuse (much of it is "on prescription") it would seem to be highly dangerous to reinforce such behavior further. Additionally it presents a dishonest reflection of reality for the patient. There is the implication that life can be lived without any pain or suffering and that all that is required is a benevolent medical profession - an omnipotently false and unjustified assumption. (p. 792)

Raphael and Walker also comment:

> He [the doctor] may give a pill where he is unable, for personal reasons, to give support in a more appropriate fashion. The comfort of his familiar medical role may alleviate his own anxieties about death and loss and aid in the denial of mortality. (p. 793)

In other words, the avoidance of intense reactions is socially reinforced. A possible explanation can be that since mourning rituals are no longer practiced and norms regarding "rites de passage" have changed, the accepted traditional support systems to the bereaved are not exercised (Gorer, 1965). Sociologically, the adoption of the medical model has filled the vacuum created following the decrease in mourning ritual practices. The physician then has become not only a caretaker for the bereaved (through reduction of "grief symptoms" by medication) but also a person who provides an alternative social support framework. The use of medication also implies that bereavement is seen as an illness rather than a normal reaction to a traumatic human experience (Schmale, 1972).

The present findings regarding widows' reported health status are seen in the context of normal reactions to the sudden loss of a spouse. They are viewed in their relationship to the social environment. Widows' responses to questions 13 to 20 in the

Demographic Questionnaire (Appendix C) were summed to obtain their reported health status score. Question 19 in the Demographic Questionnaire referred to the use of pills immediately following the loss and at present. Of the 51 widows interviewed, 28 took pills (sedatives or tranquilizers) immediately following the loss - ranging from "all the time" to "only sometimes." Sixteen widows reported they were still using pills at the time of the interview. Only one widow reported having medical problems (migraine) prior to the loss of her spouse. According to the widows, the majority were offered an injection when informed of their loss; those who agreed were encouraged to do so by their families. However, the widows repeatedly said that the injection was a mistake.

Question 20 in the Demographic Questionnaire (Appendix C) was: "Do you still suffer from any of the following?" The categories and frequencies of responses were as follows (N = 51)

Headaches - 12	24%
Insomnia - 17	33%
Bad dreams - 12	24%
Gain in weight - 3	6%
Loss of appetite - 9	18%
Weakness - 8	16%
Fatigue - 13	25%
Nervousness and crying - 18	35%

The widows' reports of their physical health indicate a social attitude as well as a personal state. This social attitude, in which

pills are given immediately following the loss as a source of comfort, not only reinforces the suppression of intense emotional reaction but also encourages the use of pills. A possible dependency on pills is understandable. Widows with low self-esteem were found to have more physical health problems several years after the loss of their spouses than did high self-esteem widows. Several explanations are possible. As was pointed out by Maddison and Raphael (1972), by Parkes (1965), and by Lindemann (1974), the use of medication prevents grief from taking its natural course. Moreover, unresolved grief may take different forms (delayed, inhibited, or chronic), with dependency on pills as one example. With regard to widows with low self-esteem, it is possible that their dependency on pills is another form of their need for emotional support. As was noted by Ben-Sira (1976), a patient makes more progress when the physician-patient relationship is based upon affective support than when the relationship is based upon instrumental support. According to Ben-Sira, the social network, in fear that affective-emotional support will increase dependency, tends to avoid such support. Instead, the support given is of the instrumental type (such as medication). In other words, refraining from affective support results in an increased dependency on pills.

The following account was told to the researcher by one of the widows:

> N. when interviewed was 33 years old, mother of two daughters aged 9 and 6. N. was born in Russia, and came to Israel with her family when she was 12. When she lost her husband during the October War, 1973, they had been married 5 years and she was expecting their second child. She was given an injection when she was informed of the loss. She said: "I was pregnant when it happened. I was quite strong

> at the beginning. Actually immediately following the loss I didn't understand what happened. I kept on telling myself - you are not the only one, there are many like you, you have to be strong. I never took pills before my husband died; today I live on pills. My parents came to live with me, but I was told that it was unhelpful for me. They cried with me instead of helping me. I was encouraged by the rehabilitation officer to try and manage without them living with me. After I gave birth, a woman stayed with me; she took care of the girls. I slept almost all the time. When I realized what happened, I broke down. I am treated by a neurologist, I take pills all the time, I see a psychologist as well. I tried to go to work; I get a monthly allowance but it is not enough since my expenses include medication and dental treatment. I worked for about a year and 4 months but things deteriorated because I had to manage everything on my own - taking care of the girls, shopping, cooking. I became even more nervous and took a leave of absence from work; it's difficult, I became very depressed, I am afraid to walk in the street by myself, I am very nervous, so are the girls; the younger one still wets the bed. I took her to see a psychologist but he wanted to see me; since I go to a neurologist I can't go to both; I'll go nuts. Things became even worse when my sister, with whom I was very close, left the country with her family. My mother is a sick person, my father is working, I am not allowed to drive, the doctor won't allow it. Actually I am very lonely.

(N. scored 19 on the self-esteem questionnaire and 10 on the Internal-External Control Scale.)

The bereavement process and grief should be viewed as normal reactions so as to emphasize that the physician is primarily a support resource and to emphasize that pills should be used only when medically justified.

Self-esteem and widows' reported helpful and unhelpful experiences: The Researchers' Questionnaire (Appendix D) was used in this study to obtain information on widows' perceived helpful and unhelpful experiences with significant others during their bereavement process.

Widows' reports were rated independently by two trained raters using the categories of type of experiences and scales of intensity of both helpful and unhelpful experiences (Appendices G and H).

Differences between high and low self-esteem widows' and type of their reported experiences, ($\underline{x}^2$=7.10(1), $\underline{p}$< .01), intensity of widows' reported helpful experiences ($\underline{x}^2$=8.95(3), $\underline{p}$< .05) and intensity of reported unhelpful experiences ($\underline{x}^2$=7.84(3), $\underline{p}$< .05) were statistically significant (Tables 14, 15). The type of widows' reported unhelpful experiences was not found to be significantly different. Pearson correlation coefficient (Table 16) revealed an association between self-esteem and the type of widows' reported helpful experiences, intensity of reported helpful experiences, and intensity of reported unhelpful experiences.

Several studies have stressed the importance of the social support network in the process of managing a traumatic experience such as the sudden loss of a spouse (Silverman, 1975; Caplan and Killilea, 1976; Lopata, 1971; Shamgar-Hendelman, 1979). Accordingly, bereavement adaptation is related more to the support system than to personality characteristics. Moreover, a traumatic event, although a negative event, has the potential of becoming a turning point that facilitates growth (Fuerst, 1967; Lynch, 1968). Also, Fuerst (1967) indicated that the most frequent experience reported as constituting a positive turning point in life was the death or illness of a relative.

In this study an attempt was made to delineate further the nature of experiences with significant others as perceived and

reported by women who were helped following the sudden loss of their spouses. The purpose was to understand, based upon the widows' subjective experience, what constitutes a helpful experience in contrast to an unhelpful one. It was assumed that people want to help when a crisis occurs, yet little is known about how these attempts to help are perceived by the bereaved. Also little is known about the relationship of personality variables to these attempts to help. It was believed that support, of prime importance during a crisis, can be more effective if it is based upon knowledge about what is perceived as helpful and unhelpful.

In this study experiences were examined according to their type and intensity. It was found that the type of helpful experiences was related to widows' level of self-esteem. Widows with high self-esteem more frequently reported emotional support, whereas widows with low self-esteem primarily reported practical-instrumental support. Helpful experiences that involved emotional support included verbal support, understanding, and encouragement. Helpful experiences that involved practical-instrumental support included such assistance as financial help, help with household activities, and shopping.

The following are examples of helpful experiences rated as emotional support. The examples and excerpts quoted in the study have been translated from Hebrew into English.

(a) "A very good friend of mine would call every day, she could tell from the tone of my voice how I felt. When she felt I needed to be comforted she would come and be with me" (I. age 31, widowed during the October war, 1973).
(b) The only one who understood me best was a friend of mine who lost her mother years ago. With her I could be myself,

she was a wonderful source of support for me, she really helped" (R. age 32, widowed during the October war, 1973).

(c) "The one who helped me most was my father. He is a warm and understanding person, my mother also helped but she is a cold type of a person, so is my brother - very formal." (A. age 29, widowed during the October war, 1973)

(d) "The widows' group - the fact that I knew there were more women in my state - that helped a lot. It was something very important for me. The first smile on my face after months and months was when I was with the widows. My mother-in-law is also wonderful, she encourages me all the time." (F. age 50, widowed during the October war, 1973)

(e) "The most exceptional help was given to me by a lawyer who volunteered to help me. That person restored my trust in human being. When I was in the most difficult moments in my life, he saw me and tried to show the nice parts as well. He helped me practically but most of all his emotional support, although he didn't have to." (I. age 37, widowed during the October war, 1973)

The following are examples of helpful experiences rated as practical-instrumental support:

(a) "My late husband used to help me do the shopping and did all the paying and arranging things. At first it was very difficult for me, I didn't even know how to go to the bank. My cousin who is an insurance man helped me a lot, took me to places. Also my sister-in-law helped me a lot." (A. age 35, was widowed 3 years when interviewed, her husband was killed on military activity)

(b) "I was in a terrible state after my husband got killed. My in-laws helped me a lot in that I saw how strong they were, not even one tear. The day following the funeral my mother-in-law prepared breakfast and said that life must go on. I was in a terrible state and everybody around me helped, they did everything for me, I knew nothing about the farm and farming, everybody decided for me, they wrapped me, they sold things for me, there was a lot of equipment. Until one morning my daughter said, mum you can forget about them selling the white tractor; only then did I realize that I have to take everything into my own hands." (V. age 41, was widowed 3 years when interviewed, her husband was killed on military service)

(c) "I got a lot of help from my brother. He helped me to find the place to live, to buy the car and start life once more. He is older than me. He called every evening and moved to live next door to him. His help was real and also

in breaking the vicious circle. He called me every evening and also visited me a lot. He played with the kids every evening and then went. At the very beginning he even fed me. My parents also helped, but he was the one to keep contact with me. He suggested I move to another apartment and also helped practically, the same with buying a car." (L. age 31, was widowed during the October war, 1973)

(d) "I am very fortunate. My family is very close to me and very helpful. They always do things for me. My brother-in-law painted the apartment for me without even me asking him to do so. I was very dependent on my husband, he did everything for me at home, after he died I learnt to do a few things. During the first year after he died my family took care of me all the time, I was very dependent on them until I decided that I have to be by myself and that I can take a decision and responsibility, they wouldn't let me do things by myself, buy things by myself and decide things for myself. I had to be alone. If I need help - they will always help me." (R. age 30, was widowed 4 years when interviewed, her husband was killed during military service)

(e) "I had a lot of help even without asking. My neighbor helped me a lot in finding things, so does my brother-in-law. He is especially helpful with the children; my husband was the one to take care of everything, now by brother-in-law helps." (R. age 33, as widowed during the October War, 1973)

In contrast to helpful experiences, the type of unhelpful experiences was not found to be associated with self-esteem. Unhelpful experiences of the emotional type were more frequently reported than unhelpful experiences of the practical-instrumental type.

Unhelpful experiences rated as emotional support were reported by 68% of the low self-esteem widows and 77% of high self-esteem widows (73% of the total sample) (Table 14). The finding indicates that, when experiencing a traumatic event such as a sudden loss of a spouse, what is perceived as unhelpful are people's comments and

attitudes rather than their actions. It is what others are saying - and not what they are doing - which is unsupportive and painful.

In addition, most unhelpful experiences fall within a few categories. These categories are explained and illustrated below.

(a) Statements relating to widows - the state of widowhood which indicate a general insensitivity to the woman's position. Widows felt that insensitivity especially when having to present formal documents, sign contracts, or change their addresses. They were always required to present their (late) husband's signatures or I.D.

(1) "I applied for a car licence. I filled the necessary forms stating my position as a widow [As a I.D.F. widow there is an exemption of taxes.] I got a letter saying my application was refused because it didn't have my husband's signature. I called and explained once more that I was a widow only to get another such letter. I felt very hurt."

(2) "I moved to a new place and went to have my address changed. I was asked to bring my [late] husband's identification card. I was so hurt and couldn't tell them I was a widow. I went home and brought it."

(b) Statements concerning I.D.F. widows in particular:

(1) "Somebody said to me, that I shouldn't complain because I get more money than some people earn. It was very painful."

(2) "Neighbors told my children that I took money from the State so I could buy a colored T.V."

(c) Statements relating to widows behavioral patterns:

(1) "I wore black clothes [a mourning custom among some ethnic groups]. People turned away from me. They said: 'You look terrible.' They didn't know nor understand how I felt."

(2) "During the "Shiva" [the seven first days of mourning following the funeral] I didn't know what I should wear. My brother-in-law suggested not to wear black clothes [as is customary among the very religious and some ethnic

groups]. I wore a suit and kept wearing it during the mourning period. It was very painful to hear people making remarks about it."

(d) Statements referring to widows' emotional expression

(1) "You think you are the only one in Israel who lost her husband? There are many like you and you must be strong. Don't cry."

(2) "You lost a husband, we lost a son; you are young and you will remarry."

The categories indicate a continuum from general statements about widows to personal statements about the widow's behavior or emotion. The statements emphasize social attitudes concerning the single women's role as well as the expectations that the widow should be strong.

As indicated previously, unhelpful experiences of the emotional-support type were similar for both high and low self-esteem widows. It would be of interest to know whether or not the level of self-esteem is associated with specific categories.

The findings in the present study suggest that satisfaction from emotional support must be treated separately. Ben Sira (1976, 1980) concluded that patients' satisfaction from physicians' affective (mode) behavior as distinct from their instrumental (content) behavior, was related to (a) patients' level of concern about their health and (b) their level of education. The findings in this study regarding widows' reports of the type of their unhelpful experiences strongly support Ben Sira's first conclusion: widow's need for emotional support is related to her emotional involvement in her

loss. The widows' relationship with others is analogous to the physician-patient relationship. In the present study no association was found between the widows' level of self-esteem and the type of reported unhelpful experiences. Unhelpful experiences of the emotional type were reported by the majority of widows. The need for support refers to the personal dimension, and satisfaction derived from it refers to the interpersonal dimension.

The question then is what is involved in the interaction between the self and others that yields different levels of satisfaction. As was established by Ziller (1974), individuals with different levels of self-esteem can evoke different levels of support. However, it is not clear whether different levels of support are given and, if so, what they are. It is the impression of the researcher that the support is related not only to the self-esteem of the bereaved but also to characteristics of the person providing the support. Obviously further research is needed on this question.

The following are examples of reported experiences of the practical-instrumental type rated as unhelpful:

(1) "My brother and sister-in-law never helped nor offered to help; they didn't understand my situation. When I decided to go to study they asked me, what for? My brother-in-law never offered to help, never took my daughters. He told me off for asking help from somebody else but never did it himself." (I. age 33, was widowed during the October War, 1973)

(2) "I have no expectation from others, I am strong and a very reserved person, I don't expect help from others. It's difficult for me to ask for help. I got no help; when I needed it, I got nothing. We were in the middle of

> building our house and my husband's business collapsed. I needed financial help, but I never got it. When I finally asked for some help for my son - a big-brother to support him, I was told to find one myself." (Z. age 31, widowed during the October War, 1973)

Although feelings of anger and frustration are identifiable, these experiences clearly focus on practical elements in contrast to unhelpful experiences, where emotional elements were dominant.

The different expressions of widows' reactions concerning their experiences were examined according to the level of intensity of the reported experiences. The intensity of helpful experiences was found to be related to the widows' level of self-esteem. A higher level of self-esteem was found to be associated with more intense helpful experiences. In contrast, lower level of self-esteem was found to be associated with more intense unhelpful experiences. The finding provides additional evidence to what has already been suggested. Intensity of the experience (level of satisfaction) refers to the interpersonal dimension. Thus, high self-esteem widows encounter more intense helpful experiences (more support), whereas low level self-esteem widows encounter more intense unhelpful experiences (less support). It should be noted that the mean level of intensity of reported unhelpful experiences was slightly higher than the mean level of intensity of the helpful one (3.12 and 2.77 respectively). It is possible that, when a needed support is perceived as unhelpful, it is more intense.

Examples of reported helpful experiences, which were classified by the raters at different levels of intensity:

(1) A mild helpful experience

(a) "It helped to know that I have a close family to turn to when I want. It gave me strength to know they were there. It gave the children a feeling of home - joint meetings, eating together, without my family I couldn't give the children a feeling of family without a man. I try to carry on as if nothing happened - entertaining and having people around." (Y. age 43, was widowed in October, 1973)

(b) "I have no expectation from anybody. I lost my parents as a young child and had to learn to struggle by myself. It helped when people said 'be strong' but at the same time it didn't help. There was no grieving. There was understanding in the kibbutz but at the same time it is a very pressuring framework." (C. age 36, was widowed in October, 1973)

(2) A helpful experience

(a) "I am lucky to have such a close family who always helped and is always ready to do things for me. I also have friends who help. Many widows ask me how is it possible to have such help without my married female friends being afraid of me "taking" their husbands. This is it with me - they know they have no reason to be afraid. I don't talk about certain things with my friends, I keep many things for myself. None of my friends have left me, they come to visit me." (S. age 30, was widowed 5 years when interviewed)

(b) "My parents helped me a lot and they still do to this day. When I studied and came back late in the evening, they took care of the children. My parents understand me and they are always available to me when I need them. They will offer help without me asking." (L. age 31, was widowed in October, 1973)

(3) A very helpful experience

(a) "My aunt, my father's sister, to whom I feel especially close, we were always close but became more so immediately after my husband's death. We talked and she understands me a lot, which gave me a very good feeling." (H. age 49, widowed during the October War, 1973)

(b) "It was important for me to do things by myself and as my husband's wife. That's why I left the 'Moshav' where we lived and moved to a town. I was very fortunate to live in a building with the most wonderful people. I moved with my four children and I cannot describe the help I was given, one family especially helped by accepting me for what I was and not as my husband's wife or a widow. It gave me a very good feeling, even though I was proud about myself for managing the way I did." (C. age 39, was widowed during the October War, 1973)

(4) A most helpful experience

(a) "My family and my friends were very helpful. Their visits, support and understanding were most important for me, it helped feeling less tense. The feeling of not being forgotten even by my husband's friends from the army was most important for me. I always felt I could talk with them without being afraid - I could be myself, I could say everything without being afraid and being judged. I could talk about my husband, I could mention sad things without any hesitations knowing I would be understood. My brothers and my brothers-in-law were very very helpful, they still are. I know that this is a two-way thing and a lot depends on me and on what I am prepared to give and do." (N. age 36, was widowed during the October War, 1973)

(b) "I was in a terrible state shortly after it happened, I lost weight, I looked terrible. I recall my mother-in-law telling us to be strong, I think it helped in that it gave me a kind of model - I was broken, I was in a terrible state - everybody around me helped. I was left with a farm which I knew nothing about. My family and my friends stayed with me 24 hours a day and helped in everything they could. I am a teacher and I didn't want to go back teaching in the same school I taught before. My supervisor helped me a lot - she backed me all along. She encouraged me to take up a job in a near-by Moshav and it was only for her that I am working there today. She believed in me, she helped me making the decision to go back to work. I wanted to stay at home and be a good mother but this wasn't for me, I could do it, I need challenges and she believed in me and encouraged me." (V. age 43, was widowed 3 years when interviewed, her husband got killed during military service)

Examples of reported unhelpful experiences, which were classified by the raters on the different levels of intensity:

(1) A mild unhelpful experience

(a) "People, especially those I didn't know said things which hurt, though I know they didn't mean to hurt, not all knew I was widowed." (B. age 31, was widowed during the October War, 1973)

(b) "In the kibbutz people want to help but they are insensitive to our needs as widows. They were not aware that as widows we might have different needs. They didn't understand our problems without children." (I. age 31, was widowed during the October War, 1973)

(2) An unhelpful experience

(a) "I cannot recall any special unhelpful experiences, in general, I remember feeling very stressed because I didn't want people to have pity on me as 'the poor wife of my husband.' I recall the presents the children got from many people who meant well but it felt strange everybody pitied us." (C. age 39, was widowed during the October War, 1973)

(b) "What was disappointing was that there was nothing from the army, they weren't interested at all in what was happening to us. I expected my husband's friends to be different and more caring and was disappointed." (I. age 33, was widowed during the October War, 1973)

(3) A very unhelpful experience

(a) "Relationships with my in-laws were very formal prior to my husband's death, I was the one to keep in contact with them, and following his death they were even more formal. I didn't like my neighbors 'to follow' me, so I moved to another apartment. I met one of my 'ex-neighbors' one day and told him that I moved because of whay they said to me. I was fed up with their wanting to know all about me and 'to help me'." (E. age 34, widowed during the October War, 1973)

(b) "My in-laws were very distanced from me, I needed help I had 2 babies to look after and it was very difficult to manage by myself. The headmaster of the school where my

husband was a teacher opened a library as a memorial for my husband, I gave all the money and I think he did it only to impress others. I expected much more practical help, I wanted people to understand that I needed help but it didn't happen. My step-mother hurt me with many things she said. My in-laws expected me to stay locked at home, they couldn't stand me taking driving lessons, I moved away from them, I couldn't stand it." (I. age 33, was widowed during the October War, 1973)

(4) A most unhelpful experience

(a) "When I was informed of my husband's death I was in a state of shock. My reaction was - how can I be left by myself, I can't be left alone, what will happen? I recall that one of my friends said - you will just have to get used to it. I was most upset. I decided that my appearance was most important. During the 'Shiva' (the first seven days following the funeral) I changed my clothes, I wanted to look good, I even started a diet. A friend met me and said - you look very well, to which I replied - yes, this situation suits me. I was so disgusted, nobody understood me, I don't even know how I could develop such a sense of humour." (S. age 42, was widowed 5 years when interviewed)

(b) "There were two people who said to me - you are not the only one, there are many like you in the country. This wasn't comforting. I needed help very badly. One of the people who said what I mentioned earlier was my mother. This put me under the most terrible pressure when she came to live with me for two months and there was a lot of tension between us. I expected her to do things in a certain way and when she didn't do it, there was a lot of tension. It's possible that it was related to the fact that we never managed before. My reaction was that I took ill and was hospitalized with high fever and a rash all over my body." (A. age 34, was widowed during the October War, 1973)

As noted, intense unhelpful experiences are more detailed.

Locus of Control and Bereavement

The rationale for inclusion of Rotter's (1966) Internal-External Control Scale was based on the assumption that information regarding widows' locus of control would be indicative of her adaptation patterns as well as her use of the support system.

The results reveal that widows interviewed in the present study showed a more external locus of control patterns. The only significant differences between "external" and "internal" groups were the relationship with widow's own family ($\underline{x}^2$=6.52(2), $\underline{p} < .05$) and the relationship with friends ($\underline{x}^2$=7.22(2), $\underline{p} < .05$). A significant correlation was found between internal-external locus of control and the following: relationship with friends ($\underline{r}$=.37, $\underline{p} < .05$), difficulties with finances ($\underline{r}$=-.24, $\underline{p} < .05$), and difficulties with old friends ($\underline{r}$=.28, $\underline{p} < .05$). All other results were not statistically significant.

According to Rotter (1966), when an event is perceived and interpreted as occurring beyond the person's control, there is a belief in external control; in contrast, when an event is perceived and interpreted by the person as contingent to his/her own behavior, there is a belief in internal control (p. 1).

Rotter's (1966) findings concern differences in a generalized belief in external-internal control and refer to a person's learning patterns. The findings in this study suggest that individuals who experienced an external traumatic event, such as the sudden loss of a spouse, tend to respond in an external direction. Widows' response patterns reveal that specific statements on the Internal-External Control Scale (Appendix B) could possibly be interpreted as a direct reflection of their experiences. The sudden death of the spouse during war or on military service is an event the widow has no control over; thus its occurence is seen as fate or bad luck.

The following statements on the Internal-External Control Scale illustrate the possibility of such interpretations:

(2a) Many of the unhappy things in people's lives are partly due to bad luck. (an external response)

(b) People's misfortunes result from the mistakes they make. (an internal response)

(3a) One of the major reasons why we have wars is because people don't take enough interest in politics. (an internal response)

(b) There will always be wars, no matter how hard people try to prevent them. (an external response)

(13a) When I make plans, I am almost certain that I can make them work. (an internal response)

(b) It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow. (an external response)

(17a) As far as world affairs are concerned, most of us are the victims of forces we can neither understand nor control. (an external response)

(b) By taking an active part in political and social affairs people can control world events. (an internal response)

This statement is of special relevance in the present study because of widows' loss of their spouses during a war or military service over which they had no control. Other statements that illustrate this interpretation are items 18, 25, and 28.

External responses to those statements are more congruent with the widows' traumatic experience, an experience over which they had no control. Another possibility is that testing conditions yielded different responses. Rotter (1966) has pointed out that different testing conditions (group vs. individual) resulted in different

responses, accounting for social desirability. However, his data refer to individual testing conditions, which resulted in higher internal means. However, in the present study individual interviews resulted in a higher external mean. The external mean scores in Rotter's various tests ranged from 5.94 to 9.56 for both sexes (Rotter, 1966, p. 15). The mean external score for the present study was 10.00, a score which can be accounted for by the subject of the interviews - widows' bereavement experiences following a sudden loss of their spouses - rather than by the test conditions. Still another possible explanation for the study's finding is that an external event, such as sudden loss of a spouse, is followed by an external reaction.

Resolution of Grief

"Anyone who mourns to excess over his deceased is actually weeping for some other reason."

Babylonian Talmud, Tractate,

Mo'ed Katan, p. 27b.

According to the Jewish mourning framework, the actual mourning period is over by the end of twelve months. This framework includes details of the stages involved and considers the bereaved person's various needs as well as the role of the support system. Thereafter, traditionally the bereaved is expected to resume normal life. Prolonged mourning, therefore, is a sign of depression for some other reason.

Several studies have stressed the importance of grief work, the intense emotional reactions following a traumatic loss (Lindemann, 1944; Bowlby, 1961; Parkes, 1975a,b; Rees, 1972; Volkan, 1976; Ramsy, 1979). Delayed, prolonged, or inhibited reactions are forms of unresolved grief associated with difficulties in experiencing intense emotional reactions. Anger, guilt, shame, and protest are some of the emotional reactions identified following a traumatic event. These negative feelings are hard to express. Denial of the loss and avoidance of intense negative emotions are common reactions. In any case, according to Hodge (1972) , uncompleted grief work will be expressed in other forms even long after the original loss occurred; grief resolution then is strongly related to bereavement adaptation. Moreover, as an intrapersonal process (intense emotional reactions), grief work (working through the loss) is dependent greatly on the social support system (the interpersonal level). Because of its importance in understanding the bereavement process and adaptation outcomes, the dimension of grief was included in the present study.

The present study evaluated grief resolution by using two of Ramsy's (1979) components of grief. These components are (1) expression of anger, bitterness, and criticism; and (2) functioning and acceptance of a new reality that excludes the deceased spouse (Appendix G).

Information about the widows' level of grief resolution was based on the interviewer's evaluation (Question 27 in the Demographic

Questionnaire, Appendix C) and the raters' assessment of the two grief components (for training and rating procedure see pp. 50-53). The Pearson coefficient of correlation between interviewer's evaluation and raters' assessment was found to be .66 ($p < .001$). Both the widows' expressions of anger, bitterness, or criticism and the widows' level of functioning and acceptance of a new reality were related to the level of self-esteem ($r = .33$, $p < .01$ and $r = -.50$, $p < .005$ respectively). The negative correlation indicates that a lower level of self-esteem is associated with more difficulties in functioning and acceptance of reality. Also the widows' level of self-esteem was related to the raters' assessment of grief resolution ($r = .46$, $p < .002$).

The following quotations illustrate the different levels of anger, bitterness and criticism:

(1) No expression of anger, bitterness or criticism

(a) "Living in the small framework of a kibbutz has many advantages, especially at the beginning, following the loss - there is a lot of consideration and physical help, but for somebody like me, who wants to carry on with life and do it my own way, this framework is too small, and even when people try to help and understand they don't succeed everyone has got his/hers own problems which are first. Even though I understood that it hurt when people tried to convince me to accept the framework - to go out and work which I didn't quite want to, then I was "stuck" on my own with two little girls, something that gave me a tremendous feeling of loneliness. I spoke very frankly with the social committee and explained to them that I have to go my own way." [A social committee is a committee elected and set up in kibbutzim as responsible for "the social wellbeing" of its members.] That's why I decided to leave the kibbutz." (L. age 29 was widowed during the October War, 1973)

(b) People in our kibbutz just didn't know how to treat us widows. The bitterness was not because people didn't help but because they didn't know how to help. I know they meant well but it was difficult for me to explain things for them, especially when it involved my children. They thought that if they don't raise issues it will be easier for me. I had to initiate talks with the teachers and explain to them what to do and what not to do. They weren't cold toward me but they weren't warm either. The need to push and explain things is important but on the other hand during that time, that was the least thing I was capable of doing." (R. age 32, widowed during the October War, 1973)

(c) "I think some of our friends kept away from me following the loss simply because it was difficult for them." (T. age 31, widowed during the October War, 1973)

(2) A minimal expression of anger, bitterness or criticism

(a) "After the initial flooding of friends they stopped coming. Partly I think its my fault, they see me "functioning as usual" so they think everything is alright. They said to me if you need any help - just ask, but its difficult for me to ask for help. I was told by friends many times that I helped them because I behaved the way I did, as they were very embarrassed." (L. age 34, was widowed 5 years when interviewed, her husband was killed during military service)

(b) "Relationships with my husband's family weren't very close before his death, I was the one who kept them going and now it is very formal. My relationship with my sister, who is the only one I got left is also not very close, I don't get on very well with my brother in-law. I would have liked to be closer to her, it does bother me. I run away from stereotypes, although it has some positive aspects: I know that being a war widow is respectable. On the other hand there is always a question about your spouse - you are not accepted as a single person." (T. age 34 was widowed during the October War, 1973)

(3) A pronounced expression of anger, bitterness or criticism

(a) "I don't expect I have no expectations. On many occasions it happened that the help wasn't natural. When a woman leaves her husband at home and comes to me every evening - that isn't natural. When you are asked "how do you do" -

in actual fact they do not want to hear what you feel. I didn't want to say what I really felt so I never answered. Once when I was asked how I felt I answered "fantastic," now I don't answer. People don't listen, if they did they should have asked "what happened?" I have learned that people are not interested in listening. I cannot say "not good," but what is so good? As for social contacts I am being forgotten, if I don't initiate social contacts nothing happens. People don't realize how lonely I feel. Today I don't initiate any social contacts others don't either even though today when I need them most." (Y. age 49, was widowed during the October War, 1973)

(b) "I don't expect anything from others. There are things that I can't even talk about like talking about my in-laws. That is a very annoying story. They didn't help, they weren't interested, they showed no interest, nothing. I know that my way of talking about death is different than other peoples way, I am very cynical perhaps because a very close person of mine had died, other people are very uncomfortable about it." (L. age 40, was widowed 3 years when interviewed)

(4) Anger, a strongly pronounced expression of anger, bitterness and criticism

(a) "I am unhappy since the loss and very bitter with the world around me. I always think: "why did it happen to me?" Not why didn't it happen to them but why me. When I see people around me and the way they behave I can't help thinking about my husband and why did he die." (D. age 50, widowed during the October War, 1973)

(b) "I was pregnant when my husband got killed. My brother in-law tried to convince me to end my pregnancy. I refused since I had already had two miscarriages and I wanted that baby. I was taken to hospital by my brother in-law where I was met by a psychologist and two of my husband's former officers. They all talked with me. I told them that if they manage to convince me I would never forgive myself and them. Although I know my brother in-law wanted to help he really did the opposite, he spoiled everything." (E. age 26 was widowed during the October War, 1973)

(c) I was criticized a lot for what I did and how I did after my husband got killed. A good friend of mine once said to me - the way you are today its not a great honor to be a friend of yours. There was a lot of pressure from my

parents, I lied to them many times especially with regard to the kids; the things they told were so painful that the only way was to escape." (A. age 44 was widowed during the October War, 1973)

The following quotations illustrate the different levels of functioning and acceptance of the new reality:

(1) A high level of functioning and acceptance of the new reality

(a) "I have discovered a new potential within myself. Before, I didn't do certain things and today I have try and decided that its better than asking others and waiting for them to do that." (I. age 39, was widowed during the October War, 1973)

(b) I am different today, I have discovered a lot of power within myself which gives me a lot of satisfaction, though its not easy." (S. age 30, was widowed during the October War, 1973)

(c) "I have three lovely very active children, I spent a lot of time with them; we talk a lot about their father and they are very proud of him. I paint, I love expressing myself through painting, everything in the house I make myself, I am proud of myself. I had a good life with my husband but now I have to manage on my own, I have accepted it." (T. 37, was widowed during the October War, 1973)

(2) A moderate functioning and acceptance of the new reality

(a) "The house is functioning all the time, if it wasn't for the girls it would have been different. I am working part-time job - my late husband's partner asked me to come back to work - it helps." (Y. age 49, was widowed during the October War, 1973)

(b) "I think what has helped, apart from going back to work was the fact that even before the loss I was a lot by myself, as my husband was in the regular army. I manage, I have no financial problems, I find things to do." (N. age 29, when interviewed was widowed 3 years, her husband was killed during military service)

(3) Some difficulties in functioning and accepting the new reality

(a) "I went back to work part-time job but for the last three years I don't function at home, I don't care, I can't. I do nothing, I know I set a bad example for my daughter, she is fifteen now. Until a few months ago she still slept with me in the same bed, the only way I could stop it was to buy her a new bedroom." (F. age 40, when interviewed was widowed 3 years)

(b) "I just don't manage by myself, wherever I have to go my brother in-law has to come with me. My husband did everything and since he died I lost my confidence. I prefer not to go out because I get embarrassed when I'm asked questions about my husband. I try to do things at home, only because of the children." (I. age 35, was widowed during the October War, 1973)

(4) A lot of difficulties in functioning and acceptance of new reality

(a) "Life for me has ended, it will never be the same, its like something within me is dead." (N. age 38, was widowed during the October War, 1973)

(b) "I see the loss as a failure. I can't change my life or be happy, I can't even smile. Economically its very difficult, since the loss everything came apart. I get nervous easily, I get angry very easily, words annoy me. I hate this and I hate that, I hate people. I get angry and ask myself why did it happen to me. I am jealous of other people." (N. age 35, was widowed 2 years when interviewed)

These quotations illustrate two distinct trends: (1) The more intense expression of anger deals with the present rather than the past. (2) Higher levels of functioning and acceptance of reality are associated with the acceptance of self in a new way, with the discovery of a new potential in the single-person role.

The study did not find a definite association between level of anger and level of functioning and acceptance although the two are related. Further research that includes other components of grief (guilt, shame, jealousy, etc.) is needed.

Resolution of grief included two levels: resolved grief and unresolved grief. (1) Resolved grief was defined as "no expression of intense negative emotions." The widow communicated the feeling: "I know that what happens to me from now on is up to me." (2) Unresolved grief was defined as "persistant, intense negative emotions." The widow communicated the feeling: "Life isn't worth it any longer. Why did it happen to me?"

The following are widows' accounts of their experience, following the notification of the death of their soldier-husbands:

Resolved grief - the experience of protest, anger, agony, and sadness:

(1) "If I met my husband today, would I have married him?"

I. age 30 married 7 years, had 2 daughters, and had been widowed 2 years at the time of the interview. Her husband served in the regular army. When her husband died, I., a teacher, was about to take a position as a head mistress in the school where she was working. I. described an experience which had elements of sadness, and depression. She said, "It was the end of the world." Yet, she also said, "It brought growth and discovery of new potential as well as a feeling of independence;" and she said, "I am different now, I was a very dependant person."

The following is the description of her experience:

> I was a very dependent person. I loved my husband a lot but I realize now that I never made one step without him. He nursed me and I enjoyed it very much. We were very close and he did everything for me. I was a very spoiled child and my husband

> kept on spoiling me. I think that's why I let people 'wrap me up' after he got killed. People were with me for 24 hours a day. I wasn't left by myself. I recall my friend saying to me two weeks after the loss that she was going out and I would stay by myself for a little while, I was frightened and panic-stricken, I was in a state of shock for 2 hours. I realized that people weren't going to be around me all the time, it scared me, I felt a total loss.

She described a lot of support from her family and in-laws, relationship with her in-laws became even closer. I. said she needed and recieved much help and support, but she rejected help that she perceived as pity. This help gave her a feeling of "over widowhood." People wanted to help but they sometimes overdid it. I. felt she experienced grief, but perhaps at that time not fully:

> It would have helped if people let me grieve more, I was strong because I was expected to be strong. Six months later I went through a crisis, then I let myself sink, which I didn't do before. I was sad and did nothing.

The crisis lasted a few months and gradually I. began to realize that "life is too dear to be missed." She left teaching and enthusiastically took art and painting classes. She said,

> Doing it gives me a great satisfaction from myself, I have also learnt to be more independent, met new people and new friends. I think of my husband from time to time and I ask myself: 'If I met him today, would I have married him?'

It seems that there are no shortcuts to the experience of grief. Sadness, agony, pain, and loneliness are emotions that if avoided immediately following the loss, will come back. I., for instance, experienced these emotions six months later. Avoidance, according to I., was associated with the help she was given to "be

strong." Experiencing grief however was followed by the emergence of a more independent person.

(2) "I needed to prove to myself that I was worthy."

A. age 39, was married 12 years with 2 children, was widowed during the October War, 1973. A. described the state of shock she was in when notified of her husband's death:

> When I was told of my husband's death, the doctor gave me a sedative which didn't help, it didn't help me to be with the people who came to see me. I couldn't and didn't believe that it happened to me. People came and were helpful, especially with the kids. I asked people for only one thing, bring me my husband. People were confused and embarassed by what I said, I knew that but I couldn't care. People didn't like and approve of what I did either. I went to the shops and bought new clothes, I had my hair done, nobody would look at me because of that, according to people this was not a proper behavior. I was a terrible mother, I wanted no responsibility, luckily the neighbors took care of my children especially my daughter who was 2 years at the time. The trouble was that I wasn't allowed to cry, when I wanted to cry I was hushed, people wanted me to be strong, crying was a sign for weakness and I realize it today. Instead of crying I did other things which people didn't like either. I had to do it, I had to prove to myself that I was worthy, I had to find out where and who was I as a woman with no husband. I went crazy, I had to go crazy, nobody understood me, nobody understood my difficulty, my being different and my need to find myself. I didn't know what was happening, I went crazy. When the rehabilitation counselor saw me, she was very worried and suggested I get some help from a psychologist, to which I immediately responded with laughter and then started crying, and finally agreed. I was helped, I came out of it stronger, I have grown. I am a different person today, more independent, more responsible, I work and enjoy my work, most of all I look at things differently today.

Protest and fear are blended with the need to be strong. This grief experience highlights not only the widow's intense reaction to the loss but also the reaction of the social environment, one which creates an additional burden. The widow was put in a "double bind"

situation. The expectation that she should be strong resulted in a reaction of "craziness," which was also rejected by the social environment. This situation could be resolved only through professional help.

Unresolved grief - the experience of "being strong:"

(1) "I knew he would do it to me."

R. age 28 with one daughter, when interviewed was widowed during the October War, 1973. R. was 20 years old and had a baby girl 3 months old when she lost her husband. When interviewed she was settling down in her new apartment after having left the kibbutz where she was born, grew up, and was married. When an appointment was made with her by the telephone, she said, "Good, at last somebody will listen to my anger." She told the interviewer:

> During the first two weeks I felt very euphoric, I didn't grasp what had happened to me. People in the kibbutz were kind and supportive. They let me do what I wanted, so I went back to work right away, but it was very difficult for me. I was working with children and couldn't devote myself to working. I decided to study physics and mathematics, nobody stopped me. Today I think that I went to study a little too early, I was neither studying nor at home. I never finished my studies. There was a lot of pressure to go back to normal routine as soon as possible and I had tried to carry on as usual, I did that through nursing the baby, that helped to a certain extent. I was surrounded with friends even when I wanted to be by myself. I never told them because I was afraid it would hurt them and they will stop coming, I was afraid they will misunderstand me, I would lose them, that's why I said nothing. I tried to join a group counseling for widows, it didn't help me to hear them talking whether they should tell their children about their daddy's death - this was not my problem. I knew when my little baby grew up I would tell her everything. The message I got from the counselor (a bereaved mother herself) was 'its much easier for you widows.' I left the group. As you can see I was very restless, trying to do things as if nothing happened. My

> in-laws didn't help either, I wanted very much that our relationship would be good, but it didn't work. They never accepted me as their son's wife and things became worse after he got killed. I am also angry with my husband for not being cautious enough. He liked taking risks, we talked about it. I always asked him to think of me as well as himself. I don't know whether I could have done something to prevent it, I guess very little but I am angry with him just as well, I always knew he would do it to me.

Elements of anger were threaded throughout the interview, which took place shortly after the widow moved to a new neighborhood, a step accompanied with both hope and despair. Her anger - directed towards officials ("Nobody tells me what to do"), towards in-laws ("never wanted me") and towards her husband ("I knew he would do it to me") - is a combination of emotions from the past as well as the present.

Adaptation to a sudden loss of a spouse requires the use of inner resources as well as external support and help. Grief work involves intense emotional reactions which are necessary for working through the loss and the acceptance of a new reality. This process necessitates facilitative conditions that emphasize the interrelationship between the individual widow and the social environment. The social attitude, as was seen from widows' accounts of their experiences, is not always congruent with their emotional needs. On the contrary, the widows are expected to be strong, when they feel very weak, sad, or angry. Their attempts to follow the expectation "to be strong" are incongruent with their emotional state. The widows' effort to avoid emotional stress is reinforced by the support system with messages like "be strong" and "don't cry" as

well as the prescription of medication "to ease the pain." The widows may "go crazy," behavior which is rejected socially but which permits professional help. Or they may experience a delayed and unresolved grief.

Support, as pointed out by Caplan & Killelea (1976), is a natural human reaction at times of a crisis. However the support is generally a "conditional support." Several explanations are offered for the phenomena of "conditional support": (a) people's fear of confronting death, (b) lack of knowledge of the grief process and its components, and (c) efforts to protect the widow from an intense experience that the social network believes will only create additional difficulties.

Help is thus either active and practical or an "encouragement" to be strong, advice which is in conflict with the very nature of the grieving process. The widow, who at that particular stage is in need of support, cannot afford to ignore the advice to be strong. The result is that statements such as "You will soon go to work" and "Time is the best healer" are perceived as most unhelpful. Also, such statements prevent grief from being expressed openly and force the widow to suppress feelings which she finds difficult to express. The "strong" widow, the widow who controls herself, is encouraged to go back to normal, to go back to work or take a job. She realizes later however that avoidance of intense emotions was not helpful. Thus, two dimensions influence the grief process: the internal dimension-widows'

emotional reactions - and the external dimension - her behavior. The support is directed mostly towards the external dimension. ("You should go to work, it will do you good." "You are young, you will remarry.") The fact that widows' refrain from expressing emotional reactions is therefore understandable. In the present study, resolution of grief and the widows' reports of unhelpful experiences were closely related.

In a study of adjustment to disability by war veterans, Marcus (1977) concluded that adjustment depended upon three independent variables: openness, coping ability, and willingness to accept help. In the present study the importance of help was recognized, and the concept of help was extended to include the level of satisfaction. Although people attempt to help, not all efforts are perceived as helpful. This discrepancy is specially evident with emotional support.

Widows' level of self-esteem and resolution of grief indicate a similar pattern to the one found in regard to type of reported helpful experiences and intensity of helpful and unhelpful ones. Widows' level of self-esteem was found to be associated with their resolution of grief. The "support paradox" is obvious. High self-esteem widows evoke and receive more support; low self-esteem widows who need the same support, if not more, are less capable of evoking it. The reported unhelpful experiences of the low self-esteem widows are more intense and more of the widows have not resolved grief. The accepted notion that time is the best healer does not apply to them, as it does

for those who resolved grief. Recent studies (Ramsy, 1979; Mawson et al., 1981) have reported newly developed therapeutic interventions focused on unresolved grief lasting up to 10 years.

Bereavement adaptation, physical health, experiences with significant others, and resolution to grief were examined in relation to the personality variables of self-esteem and locus of control. In addition, a factor analysis was applied in order to identify the variables that can explain the outcomes of bereavement. The analysis supplies further support to the previously observed trend that the support provided by significant others influences bereavement adaptation and resolution of grief (Table 22). The items grouped in Factor I direct attention to positive bereavement outcomes. The items were frequent contact with friends (10), a high level of satisfaction (11), a low level of difficulties with children (13) and with new friends (19) (both correlate negatively with the Factor indicating less difficulties), intensity of helpful experiences (22), and fewer difficulties in functioning and accepting a new reality (25) (a negative correlation with the factor signifies less difficulties), level of self-esteem (26), and locus of control (27). The personality variable locus of control appears to load high on the Factor with items which were already found to be significantly related (10, 22, 23).

Factors II and III point in the opposite direction to Factor I. Two elements - level of difficulties with children (13) and intensity

of helpful experiences (22) - load high on both Factor I and II, the difference being the direction of the correlation with the corresponding Factor. Level of difficulties with children correlates positively with Factor II, indicating a high level of difficulties (the opposite direction to that on Factor I). Also intensity of helpful experiences (which correlated positively on Factor I) is negatively correlated with Factor II, in the direction of less intense helpful experiences.

In the process of bereavement, relationship with in-laws is of special interest. It should be remembered that the in-laws are bereaved parents who go through the experience of grief themselves. It is the impression of the researcher that the widow's relationship with her in-laws, following the loss (of husband and son) could be an important source of information in evaluating bereavement outcomes. Statements such as "You lost a husband, we lost our son" and "Why him, not you" are examples of widows' reported encounters in which obvious anger was expressed. Along the other side of the continuum were reports such as "We all lost somebody who is dear to us" and "I know it was difficult for my in-laws, I helped them a lot." In some cases, following the initial reaction of shock and anger on both sides, relationships were resumed, if only because of the children. On other occasions, the relationship deteriorated completely to a point where the children became the issue for arguments between both sides.

Intensity of unhelpful experiences (23) (which load highest on the factor), high level of anger, bitterness and criticism (24) and difficulties in functioning and acceptance of reality are grouped on Factor II, a grouping which indicates a negative experience.

Factor III is yet another possible indicator of bereavement outcomes. Many health problems (6), which correlate positively with Factor III, are associated with high level of difficulties in going out to work (27) and fewer contacts with the widows' own family (8). There seems to be an increase in health problems with the decrease in an important source of support, such as the widow's own family. Also, more health difficulties affect the widows' willingness to go to work.

Research Procedures

The nature of the present study - bereavement resulting from a sudden loss of a spouse - requires an ex post facto research design. The intensity of the experience required an individual interview with each widow participating in the study. The results and interpretations in the present research are limited to the specific sample and are not generalized. Nevertheless, any information on the subject of adaptation to bereavement following a sudden loss of a spouse has the potential of broadening professional understanding.

I.D.F. widows represent a group that is in many ways unique within the population of bereaved families and widows in Israel. Both the circumstances of the loss (through war or military service) and the institutionalized support system (The Rehabilitation Department of

the Ministry of Defense) have influenced the general social attitude towards this group of widows. The husbands have lost their lives in circumstances meaningful to Israeli society at large. Also as I.D.F. widows they are entitled to comprehensive financial care, which separates them from all other groups of widows in Israeli society.

In order to obtain information on such a delicate and complex subject, it was important to construct the interview framework in a way that would reinforce the widows' interest and their willingness to take part actively during the interview. Most of the widows were willing to participate in the study and indicated that they wanted to share their personal experience so that those involved in helping the bereaved people could better understand the bereavement process A typical comment was the following: "If it won't help me personally, I would very much hope it would help other new widows."

The interview consisted of two parts - unstructured and structured. During interviews with 15 widows prior to the study, it was realized that, when the interviewer established rapport with the widows, they became highly involved, sharing voluntarily very meaningful information. Thus, it was decided to include information obtained in the unstructured part of the study as part of the data collected. An additional benefit of the individual interview was its implicit therapeutic effects. Ventilation was especially meaningful for many widows, who discussed some topics for the first time.

Thus, the interviews were therapeutic in the sense that many meaningful human encounters have a therapeutic effect. Rogers' (1980) extension of his concept of client-centered therapy to person-centered relationships is very pertinent to the problem of interviewing widows. It should be stressed that the selection and training of interviewers for such research studies should include information about death, bereavement, and grief as well as interviewing skills.

The structured part included the administration of the questionnaires during the second part of the interview. This order enabled a more formal termination. It is recommended that an unstructured or semi-structured interview be used when interviewing bereaved people so as to enable the bereaved to give a full and detailed account of his or her experience. This account then can be assessed by trained raters.

CHAPTER SIX
SUMMARY AND CONCLUSIONS

Bereavement adaptation and resolution of grief were examined in relationship to selected personality variables. Individual interviews were conducted with 51 widows who suddenly lost their spouses in war or during military service. The interviews, consisting of structured and unstructured parts, emphasized the widows' subjective bereavement experiences.

The study explored two personality variables: self-esteem and perception of events as controlled internally or externally. Self-esteem was measured with Ziller's (1973) subtest of self-esteem; perception of control was measured with Rotter's (1966) internal-external control scale. Bereavement adaptation and resolution of grief were assessed with (a) a questionnaire about physical health and difficulties at home, with families, and in social activities and (b) open-ended questions concerning helpful and unhelpful experiences with significant others.

The study indicated a relationship between self-esteem and bereavement adaptation, but it did not indicate a relationship between internal-external perception of control and bereavement adaptation.

The widows' scores on the internal-external control scale were substantially higher in perception of control as external than the scores found in a random sample. These high scores may result from the design of the study. The testing conditions, in which each widow completed the questionnaire during an interview focused exclusively

upon the subject of sudden loss and bereavement, may have yielded more external responses from the widows than might have been obtained in a different context. On the other hand, persons who have experienced the traumatic, sudden death of their spouses may become more externally-oriented than they were prior to this loss. Further investigation is needed to determine the reason for these high scores. Under different test conditions, possibly with the administration of the questionnaire to a heterogenous group composed of widows and non-widows, the widows might respond from the broader perspective of diverse life experiences rather than from the narrowly-focused perspective of war widows.

Both subjective and objective evaluation of bereavement adaptation and resolution of grief produced similar results. The widows' comments about their bereavement experiences and adaptation to the loss of their husbands was in accord with the factual data concerning their situation, a similarity suggesting that both high and low self-esteem widows were realistic in their assessment. The subjective evaluation of the researcher, based upon the widows' comments during the interviews, correlated highly with the objective evaluation of independent raters, who analyzed the types of data that prior studies have established to be strong indicators of bereavement adaptation and resolution of grief.

Ziller's self-esteem test, used in its Hebrew version, indicated that widows with high self-esteem made a more positive adaptation to

the loss of their husbands than did widows with low self-esteem. The two groups of widows differed significantly in terms of reported financial difficulties, health problems, and helpful and unhelpful experiences with significant others.

Financial difficulties were more frequently reported by widows with low self-esteem than by widows with high self-esteem. This finding is of particular significance because all the widows in the study received substantial financial support from the Israel Defense Forces. Unlike most widows, whose income is typically reduced after the death of their husbands, the widows in the study received an income that should have permitted them to maintain a standard of living at least as high as before the loss of their husbands. Since widows with low self-esteem, in contrast to widows with high self-esteem, were often unable to obtain adequate emotional support from friends and relatives, their financial problems may, in fact, be a plead for emotional support.

The dimension of health is an important indicator of bereavement adaptation and resolution of grief. Psychophysiological reactions are substantial, but normal, following a traumatic event. Most bereaved persons avoid talking about these reactions because of their intensity. Yet these psychophysiological reactions have an overwhelming effect upon the bereaved and the social network. Persons respond by attempting to reduce the pain and distress of the bereaved. The result is the widespread use of medication soon after

the death of a spouse, medication which prevents grief from taking its natural course.

The use of medication implies that the bereaved and those within the support system see bereavement as an illness in which the physician's role is to heal the body rather than to support the bereaved emotionally. Moreover, with the decrease in the practice of mourning rituals in Western society, the medical model, with its emphasis upon medication, has become an accepted substitute.

More than half, 27 widows (54%), of the widows reported the use of pills immediately after the loss of their husbands, and 16 widows (31%) reported that they were still taking pills. Also, psychophysiological reactions such as insomnia and headaches were still present, even after several years.

Physical health problems were more frequently reported by widows with low self-esteem than by widows with high self-esteem. These physical health problems may be an expression of emotional difficulties in a form that is socially acceptable. The prevalance of health problems among these widows is similar to the phenomenon of financial difficulties in that both elicit a practical-instrumental response rather than an emotional response.

The helpful and unhelpful experiences reported by the widows were a significant dimension in the study. Attempting to help a distressed person is a natural human reaction to a crisis. However, little is known about how these attempts to help are perceived by the person in

distress. In this study, widows responded to open-ended questions about their positive and negative experiences with significant others. These responses were assessed according to type and intensity. Experiences were categorized as providing either emotional support (expression of sympathy, understanding, encouragement) or practical-instrumental support (babysitting, help with household chores, money, medication).

The responses concerning helpful and unhelpful experiences with significant others were different for widows with high self-esteem than for those with low self-esteem. The number of helpful experiences was larger for widows with high self-esteem. Widows with high self-esteem more frequently reported emotional support, but widows with low self-esteem more frequently reported practical-instrumental support. In addition, widows with high self-esteem reported more intense helpful experiences; in contrast, widows with low self-esteem reported more intense unhelpful experiences. However, for both groups the mean intensity of unhelpful experiences was higher than the mean intensity of helpful experiences.

The type of unhelpful experiences reported by the widows was not associated with their level of self-esteem. Most unhelpful experiences were, in fact, emotional rather than practical-instrumental. When reporting unhelpful experiences, the widows primarily mentioned the attitudes and comments of friends and relatives. Most of these unhelpful experiences made reference to (a)

the general state of widowhood or the single woman, (b) the position of an I.D.F. widow, (c) the widow's behavioral patterns, or (d) the widow's emotional state.

The study assessed the extent to which grief had been resolved. Resolution of grief, like bereavement adaptation, was determined by the researcher's subjective evaluation, based upon the widow's comments during the interview, and by the objective evaluation of two raters. The two methods produced a high correlation. The study indicated that the widows with high self-esteem had more positive outcomes than widows with low self-esteem.

The study indicated that the widows tended to avoid grief work, especially when it involved the negative feelings of anger, guilt, or protest. Furthermore, friends and relatives reinforced this avoidance, presumably because they lacked knowledge about the natural grief process and because they mistakenly believed that "being strong" would help. This attitude of friends and relatives was detrimental to positive outcomes because the natural process of grief required the expression of intense emotions and because the widows needed emotional support in order to deal effectively with the loss of their husbands. With this conflict between the widow's need to do grief work and the prohibition of strong emotions by friends and relatives, it was not surprising that the widows reported so many intensely unhelpful experiences of an emotional type.

Practical-instrumental support also reinforced the tendency to avoid grief work. As noted earlier, financial difficulties and poor

physical health -- factors associated with low self-esteem -- were possibly related to the widows' inhibition of emotions. Practical-instrumental support may delay or prevent the resolution of grief if it serves as a substitute for emotional support. Obviously, an unconditional emotional support is of utmost importance for widows experiencing intense, but necessary, emotions.

The low but significant correlation between two of the variables, self-esteem and bereavement adaptation, suggests further study. The low correlation may be due to (a) the faulty construction of the Demographic Questionnaire, (b) the small size of the sample, (c) the use of the Pearson correlation coefficient, which assumes a linear relationship between the variables, and (d) the fact that bereavement outcomes are truly not strongly related to personality variables.

The social support variable was found to be a central variable in bereavement adaptation and grief resolution. As a result, the researcher recommends that further studies treat the social support variable as an independent variable, an approach that will enable the study of its relationship to different factors of bereavement adaptation and resolution of grief.

A factor analysis suggested the importance of the support system during the process of bereavement. Furthermore, some attitudes and behavior of friends and relatives were associated with positive outcomes, whereas different ones were associated with continuing difficulties and negative outcomes. The widows tended to express

emotion in a mode compatible with what friends and relatives considered to be socially acceptable. Thus, social attitudes contrary to the natural grief process delayed or prevented a satisfactory resolution of grief.

Both internal and external factors were associated with positive outcomes. These internal factors were a high level of satisfaction with present adjustment and more intense helpful experiences, whereas the external factors were more frequent contact with friends and fewer difficulties with the children. Contrasting factors were associated with negative outcomes. The internal factors were a high level of anger or criticism and more intense unhelpful experiences; the external factors were fewer contacts with in-laws and the widow's own family, and more difficulties with the children.

The trends identified in the study provide an important additional source of understanding the effect of the social environment upon bereavement adaptation and resolution of grief. Of special significance are the findings that the widow's perception of what is helpful differs substantially from the beliefs of friends and relatives about what is helpful. The researcher strongly recommends that professional helpers inform both widows and significant others about the phases of the bereavement process, grief work, and the role of the support systems.

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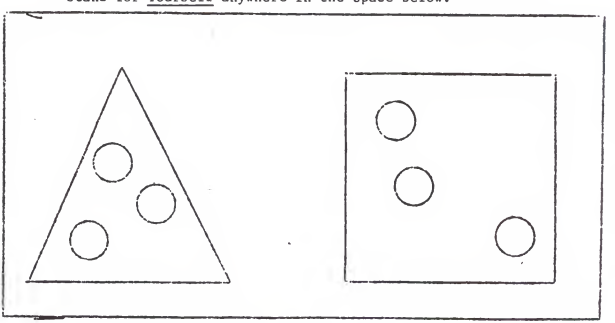
APPENDIX A
SELF SOCIAL SYMBOLS TASKS
English

1. The circles below stand for people. Mark each circle with the letter standing for one of the people in the list. Do this in any way you like, but use each person only once and do not omit anyone.

F - Someone who is failing in business
H - The happiest person you know
K - Someone you know who is kind
S - Yourself
SU - Someone you know who is successful
ST - The strongest person you know

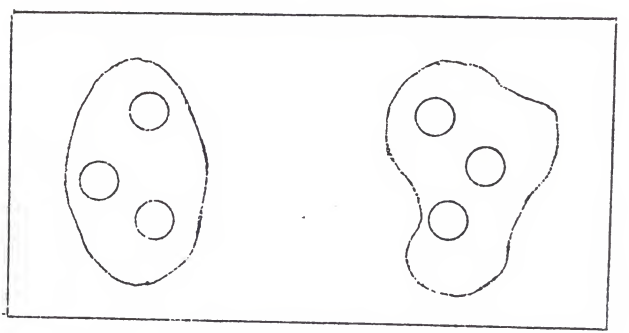
2. The two figures below stand for two groups of people you know. The small circles stand for other people. Draw a circle to stand for Yourself anywhere in the space below.



3. The circles below stand for people. Mark each circle with the letter standing for one of the people in the list. Do this in any way you like, but use each person only once and do not omit anyone.

D - Doctor	M - Mother
Fa - Father	S - Yourself
Fr - Friend	C - Clergyman

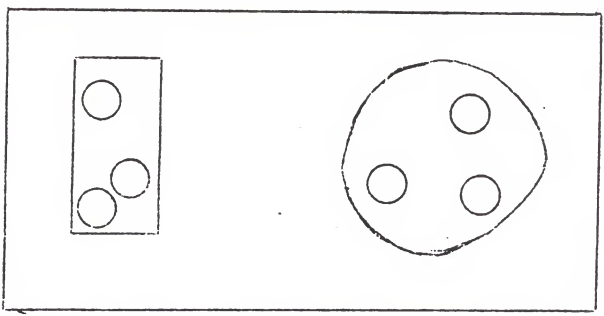
4. The two figures below stand for two groups of people you know. The small circles stand for other people. Draw a circle to stand for <u>Yourself</u> anywhere in the space below.



5. The circles below stand for people. Mark each circle with the letter standing for one of the people in the list. Do this in any way you like, but use each person only once and do not omit anyone.

A - Someone you know who is a good athlete
P - Someone you know who is popular
F - Someone you know who is funny
G - Someone who knows a great deal
S - Yourself
U - Someone you know who is unhappy

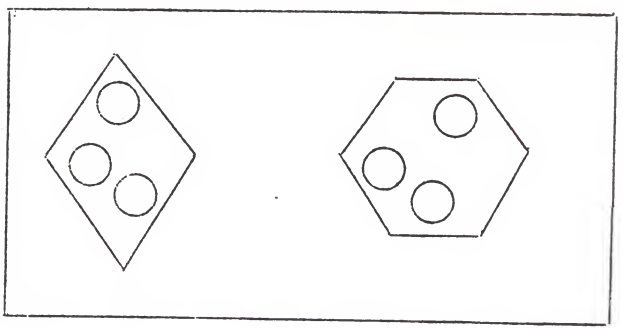
6. The two figures below stand for two groups of people you know. The small circles stand for other people. Draw a circle to stand for <u>Yourself</u> anywhere in the space below.



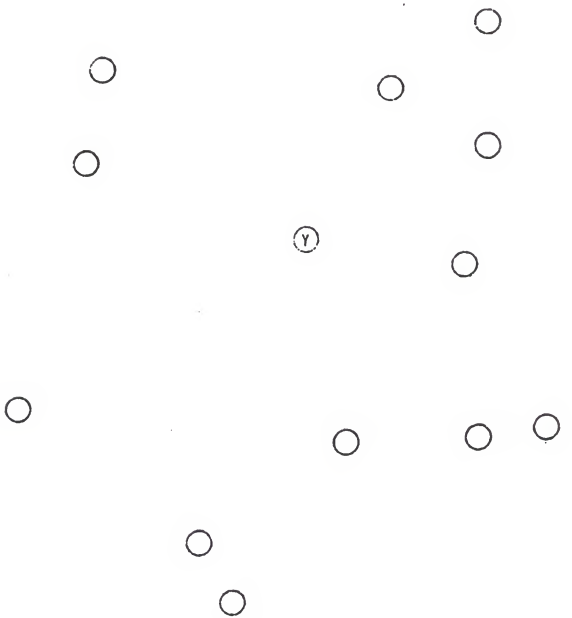
7. The circles below stand for people. Mark each circle with a letter standing for one of the people in the list. Do this in any way you like, but use each person only once and do not omit anyone.

A - An actor
B - Your brother or someone like a brother
F - Your best friend
S - Yourself
SA - A salesman
P - A politically active person

8. The two figures below stand for two groups of people you know. The small circles stand for other people. Draw a circle to stand for <u>Yourself</u> anywhere in the space below.



9. The circle marked "Y" stands for Yourself. The other circles stand for other people. Draw as many or as few lines as you wish from the circle for Yourself to the circles which stand for other people.



10. The circles below stand for people. Mark each circle with a letter standing for one of the people in the list. Do this in any way you like, but use each person only once and do not omit anyone.

Y - Yourself
S - Your sister or someone most like a sister
F - A fireman
C - A cruel person
W - Someone who has learned a lot
L - A lucky person

11. The circles below stand for people. Mark each circle with a letter standing for one of the people in the list. Do this in any way you like, but use each person only once and do not omit anyone.

D - Doctor
F - Father
Fr - Friend
N - Nurse
S - Yourself
U - Someone you know who is unsuccessful

Intructions: Here is a list of words. You are to read the words quickly and check each one that you think describes YOU. You may check as many or as few words as you like - but be HONEST. Don't check words that tell what kind of a person you should be. Check words that tell you what kind of a person you really are.

1. _____ able	23. _____ clean	45. _____ generous
2. _____ active	24. _____ clever	46. _____ gentle
3. _____ afraid	25. _____ comfortable	47. _____ glad
4. _____ alone	26. _____ content	48. _____ good
5. _____ angry	27. _____ cruel	49. _____ great
6. _____ anxious	28. _____ curious	50. _____ happy
7. _____ ashamed	29. _____ delicate	51. _____ humble
8. _____ attractive	30. _____ delightful	52. _____ idle
9. _____ bad	31. _____ different	53. _____ important
10. _____ beautiful	32. _____ difficult	54. _____ independent
11. _____ big	33. _____ dirty	55. _____ jealous
12. _____ bitter	34. _____ dull	56. _____ kind
13. _____ bold	35. _____ dumb	57. _____ large
14. _____ brave	36. _____ eager	58. _____ lazy
15. _____ bright	37. _____ fair	59. _____ little
16. _____ buzy	38. _____ faithful	60. _____ lively
17. _____ calm	39. _____ false	61. _____ lonely
18. _____ capable	40. _____ fine	62. _____ loud
19. _____ careful	41. _____ fierce	63. _____ lucky
20. _____ careless	42. _____ foolish	64. _____ mild
21. _____ charming	43. _____ friendly	65. _____ miserable
22. _____ cheerful	44. _____ funny	66. _____ modest

67. _____ neat
68. _____ old
69. _____ patient
70. _____ peaceful
71. _____ perfect
72. _____ pleasant
73. _____ polite
74. _____ poor
75. _____ popular
76. _____ proud
77. _____ quiet
78. _____ quick
79. _____ responsible
80. _____ rough
81. _____ rude
82. _____ sad
83. _____ selfish
84. _____ sensible
85. _____ serious
86. _____ sharp
87. _____ silly
88. _____ slow
89. _____ small
90. _____ smart
91. _____ soft
92. _____ special
93. _____ strange
94. _____ stupid
95. _____ strong
96. _____ sweet
97. _____ terrible
98. _____ ugly
99. _____ unhappy
100. _____ unusual
101. _____ useful
102. _____ valuable
103. _____ warm
104. _____ weak
105. _____ wild
106. _____ wise
107. _____ wonderful
108. _____ wrong
109. _____ young

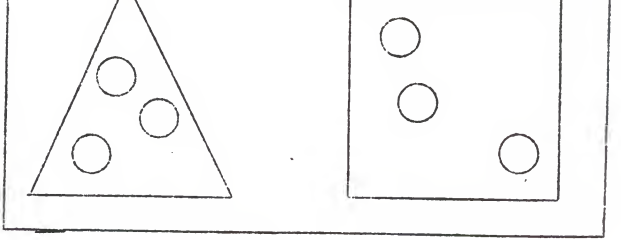
מסלות לסמלים של העצמי-החברתי
HEBREW

1. העגולים למטה מציינים אנשים. סמן כל עגול מהעגולים למטה באות שמציינת כל אחד מהאנשים ברשימה. את/ה יכול/ה לעשות זאת באיזו צורה הנראית לך, אך סמן/ני כל אחד מהאנשים רק פעם אחת והשתדל/י לא להחסיר אף אחד...

נ - מישהו שנכשל בעסקים
מ - האדם המאושר ביותר שאת/ה מכיר/ה
א - מישהו אדיב/ה שאת/ה מכיר/ה

ע - את/ה עצמך
מצ- מישהו מצליח שאת/ה מכיר/ה
ח - האדם החזק ביותר שאת/ה מכיר/ה

2. שתי הצורות למטה מציינות קבוצות של אנשים שאת/ה מכיר/ה. העגולים הקטנים מציינים אנשים אחרים. סמן/ני עגול המציין את עצמך בכל מקום הנראה לך בשטח שלמטה.

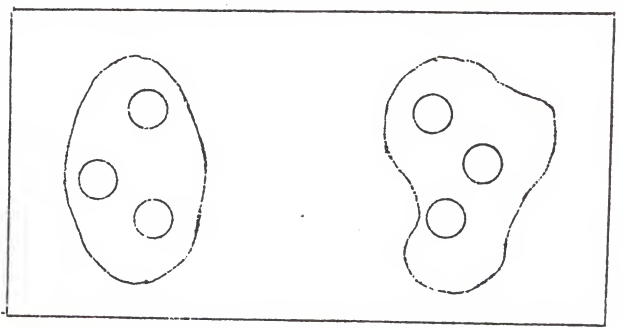


3. העגולים למטה מציינים אנשים. סמן/ני כל עגול מהעגולים למטה, באות שמציינת כל אחד מהאנשים ברשימה. את/ה יכול/ה לעשות זאת באיזו הבראית לך, אך סמן/ני כל אחד מהאנשים רק פעם אחת ותשתדל/י לא להחסיר אף אחד.

רו- רופא
א - אבא
ח - חבר

אמ- אמא
ע - עצמך
ר - רבי

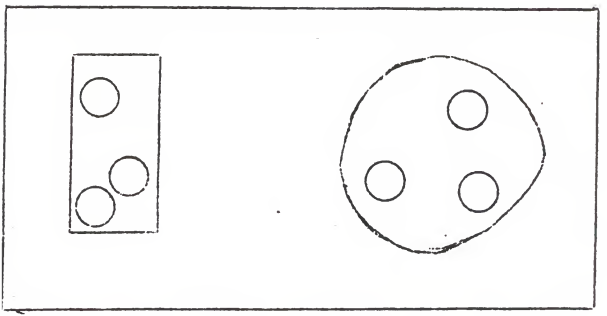
4. שתי הקבוצות למטה מציינות שתי קבוצות של אנשים שאת/ה מכיר/ה. העגולים הקטנים מציינים אנשים אחרים. סמן/ני עגול המציין את <u>עצמך</u> בכל מקום הנראה לך, בשטח שלמטה.



5. העגולים למטה מציינים אנשים. סמן/ני כל עגול מהעגולים למטה באות שמציינת כל אחד מהאנשים ברשימה. את/ה יכול/ה לעשות זאת באיזו צורה הנראית לך, אך סמן/ני כל אחד מהאנשים רק פעם אחת והשתדל/י לא להחסיר אף אחד.

ס - מישהו שאת/ה מכיר/ה שהוא ספורטאי
פ - מישהו שאת/ה מכיר/ה שהוא פופולרי
מ - מישהו שאת/ה מכיר/ה שהוא מצחיק
י - מישהו שיודע הרבה
ע - עצמך
למ- מישהו שאת/ה מכיר/ה שהוא לא מאושר

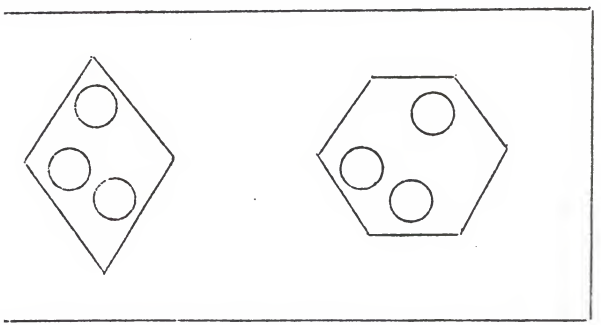
6. שתי הצורות למטה מסמלות שתי קבוצות של אנשים שאת/ה מכיר/ה. העגולים הקטנים מציינים אנשים אחרים. סמן/ני עגול בכל מקום הנראה לך המציין את <u>עצמך</u> בשטח שלמטה.



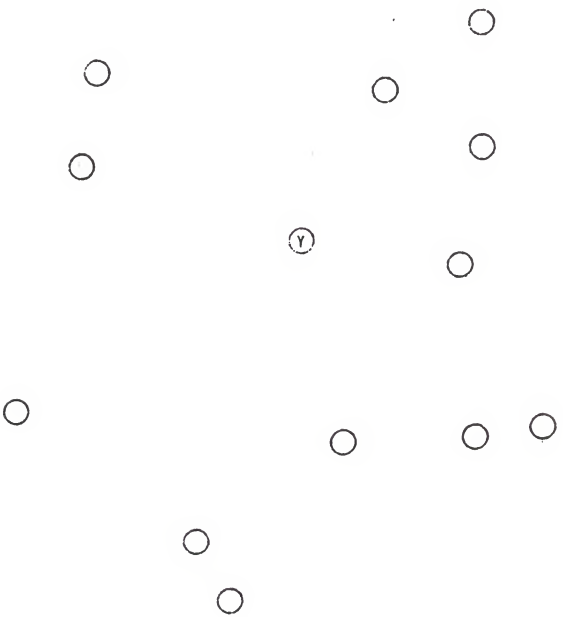
7. העגולים למטה מציינים אנשים. סמן/נ׳ כל עגול מהעגולים למטה באות שמציינת כל אחד מהאנשים ברשימה. את/ה יכול לעשות זאת באיזו צורה הנראית לך, אך סמן כל אחד מהאנשים רק פעם אחת והשתדל/י לא להחסיר אף אחד.

ש - שחקן
א - את או מישהו קרוב כמו את
ח - החבר/ה הטוב/ה ביותר שלך
ע - עצמך
ס - סוחר
פ - אדם פעיל בפוליטיקה

8. שתי הצורות למטה מסמלות שתי קבוצות אנשים שאת/ה מכיר/ה. העגולים הקטנים מציינים אנשים אחרים. סמן/נ׳ עגול המציין את <u>עצמך</u> בכל מקום הנראה לך בשטח שלמטה.



9. העגול המסומן ב-ע מציין את עצמך. העגולים האחרים מציינים אנשים אחרים. העבר/י קוים, כמה קוים שתרצה/צי, <u>מהעגול של עצמך</u>, לעגולים המציינים אנשים אחרים.



10. העגולים למטה מציינים אנשים. סמן/ני כל אחד מהעגולים למטה, באות שמציינת כל אחד מהאנשים ברשימה. את/ה יכול/ה לעשות זאת באיזו צורה שנראית לך, אך סמן/ני כל אחד מהאנשים רק פעם אחת והשתדל/י לא להחסיר אף אחד.

ע - עצמך
א - אחות או מישהו קרוב כמו אחות
מ - כבאי (מכבה אש)
אא- אדם אכזר
ל - מישהו שלמד הרבה
ב - אדם בר מזל

11. העגולים למטה מציינים אנשים. סמן/ני כל אחד מהעגולים למטה באות שמציינת כל אחד מהאנשים ברשימה. את/ה יכול/ה לעשות זאת באיזו צורה הנראית לך, אך סמן/ני כל אחד מהאנשים רק פעם אחת והשתדל/י לא להחסיר אף אחד.

רו- רופא
אב- אבא
ח - חבר/ה
אח- אחות בבית חולים
ע - עצמך
למ- מישהו המוכר לך שאינו מצליח

12. הוראות: לפניך רשימת מלים. את/ה מתבקש/ת לקרוא את הרשימה במהירות ולסמן כל אותן מלים המתארות את עצמך. את/ה יכול/ה לסמן כמה מלים שאת/ה רוצה, אולם בכנות.
<u>אל תסמן/ני מלים המתארות כיצד הינית רוצה להיות</u>. סמן/ני מלים המתארות אלזה/זו אדם אתה באמת.

1. ___אדיב
2. ___אומלל
3. ___אחראי
4. ___אמיץ
5. ___אנוכי
6. ___אויל
7. ___אכזר
8. ___איטי
9. ___בעל יכולת
10. ___בעל תועלת
11. ___בעל ערך
12. ___בודד
13. ___בטלן
14. ___בר מזל
15. ___גדול
16. ___גלמוד
17. ___גאה
18. ___גס
19. ___דואג
20. ___דל
21. ___הגון
22. ___זהיר
23. ___חלש
24. ___חם
25. ___חושש
26. ___חכם
27. ___חברי
28. ___חזק
29. ___חשוב
30. ___חריף
31. ___טועה
32. ___טפשי
33. ___טוב
34. ___טוב לב
35. ___יפה
36. ___כעסן
37. ___לא אמיתי
38. ___לא מאושר
39. ___גאה
40. ___בישן
41. ___מריר
42. ___מבריק
43. ___מוכשר
44. ___מקסים
45. ___מרוצה
46. ___מלוכלך
47. ___מתלהב
48. ___משעשע
49. ___מרשים
50. ___מאושר
51. ___מתון
52. ___מטודר
53. ___מבוגר
54. ___מושלם
55. ___מסכן
56. ___מעודן
57. ___משביע רצון
58. ___זריז
59. ___מחוספס
60. ___מטופש
61. ___מיוחד
62. ___מוזר
63. ___חמוד
64. ___מכוער
65. ___נקי
66. ___נעים

67. ___נאה
68. ___נבון
69. ___נינוח
70. ___נאמן
71. ___החלטי
72. ___נדיב
73. ___נוהג
74. ___נמוך
75. ___נעים
76. ___נוראי
77. ___נהדר
78. ___סקרן
79. ___עסוק
80. ___עליז
81. ___עדין
82. ___עצמאי
83. ___עצל
84. ___ערני
85. ___סבלני
86. ___עצוב
87. ___פעיל
88. ___פזיז
89. ___פופולרי
90. ___פראי
91. ___פקח
92. ___קשה
93. ___קנאי
94. ___קולני
95. ___רע
96. ___רגוע
97. ___רחב לב
98. ___צנוע
99. ___צעיר
100. ___רציני
101. ___רגיש
102. ___שלו
103. ___רך
104. ___שקט)
105. ___שונה
106. ___שמח
107. ___תקיף
108. ___שחקן
109. ___ציית

APPENDIX B
THE I-E CONTROL SCALE
English

1.a. Children get into trouble because their parents punish them too much.

b. The trouble with most children nowadays is that their parents are too easy with them.

2.a. Many of the unhappy things in people lives are partly due to bad luck.

b. People's misfortunes result from the mistakes they make.

3.a. One of the major reasons why we have wars is because people don't take enough interest in politics.

b. There will always be wars, no matter how hard people try to prevent them.

4.a. In the long run people get the respect they deserve in this world.

b. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.

5.a. The idea that teachers are unfair to students is nonsense.

b. Most students don't realize the extent to which their grades are influenced by accidental happenings.

6.a. Without the right breaks one cannot be an effective leader.

b. Capable people who fail to become leaders have not taken advantage of their opportunities.

7.a. No matter how hard you try some people just don't like you.

b. People who can't get others to like them don't understand how to get along with others.

8.a. Heredity plays the major role in determining one's personality.

b. It is one's experience in life which determine what they are like.

9.a. I have often found that what is going to happen will happen.

b. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.

10.a. In the case of a well prepared student there is rarely if ever such a thing as an unfair test.

" b. Many times exam questions tend to be so unrelated to course work that studying is really useless.

11.a. Becoming a success is a matter of hard work, luck has little or nothing to do with it.

b. Getting a good job depends mainly on being in the right place at the right time.

12.a. The average citizen can have an influence in government decisions.

b. This world is run by the few people in power, and there is not much the little guy can do about it.

13.a. When I make plans, I am almost certain that I can make them work.

b. It is not always wise to plan too far ahead because things turn out to be a matter of good or bad fortune anyhow.

14.a. There are certain people who are just no good.

b. There is some good in everybody.

15.a. In my case getting what I want has little or nothing to do with luck.

b. Many times we might just as well decide what to do by flipping a coin.

16.a. Who gets to be the boss often depends on who was lucky enough to be in the right place first.

b. Getting people to do the right thing depends upon ability, luck has little or nothing to do with it.

17.a. As far as world affairs are concerned, most of us are the victims of forces we can neither understand, nor control.

b. By taking an active part in political and social affairs the people can control world events.

18.a. Most people don't realize the extent to which their lives are controlled by accidental happenings.

b. There really is no such thing as "luck."

19.a. One should always be willing to admit mistakes.

b. It is usually best to cover up one's mistakes.

20.a. It is hard to know whether or not a person really likes you.

b. How many friends you have depends upon how nice a person you are.

21.a. In the long run the bad things that happen to us are balanced by the good ones.

b. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.

22.a. With enough effort we can wipe out political corruption.

b. It is difficult for people to have much control over the things politicians do.

23.a. Sometimes I can't understand how teachers arrive at the grades they give.

b. There is a direct connection between how hard I study and the grades I get.

24.a. A good leader expects people to decide for themselves what they should do.

b. A good leader makes it clear to everybody what their jobs are.

25.a. Many times I feel that I have little influence over the things that happen to me.

b. It is impossible for me to believe that chance or luck plays an important role in my life.

26.a. People are lonely because they don't try to be friendly.

b. There is not much use in trying too hard to please people, if they like you, they like you.

27.a. There is too much emphasis on athletics in high school.

b. Team sports are an excellent way to build character.

28.a. What happens to me is my own doing.

b. Sometimes I feel that I don't have enough control over the direction my life is taking.

29.a. Most of the time I can't understand why politicians behave the way they do.

b. In the long run the people are responsible for bad government on a national as well as on a local level.

ה ו ר א ו ת

HEBREW

כל פריט ברשימה הבאה מורכב משתי אפשרויות המסומנות (א) או (ב). בחר באותו משפט מכל זוג אשר נראה לך האמיתי ביותר. השתדל לבחור במשפט שאתה באמת מאמין שהוא נכון יותר - ולא במשפט שהנך חושב שעליך לבחור בו, או שהיית רוצה שיהיה אמיתי. סולם זה מעריך אמונה או חוות-דעת אישית ולכן אין כאן תשובות "נכונות" או "בלתי נכונות."

ענה נא על פריט בזהירות. ענה על כל שאלה על ידי הקפת האות (א) או (ב) בעיגול.

יהיו מקרים שתאמין בנכונות שתי האפשרויות. במקרים אלו בחר באותה אפשרות הקרובה ביותר לרגשותיך.

שם _____ מין ז - נ

משפחה פרטי

מקום _____ תאריך ___/___/___

א נ י מ א מ י ן ב י ת ר ת ו ק ף ש . . .

1. א. ילדים נכנסים לצרות מפני שהוריהם מעניקים להם יותר מדי.
   ב. הצרה עם רוב הילדים בימינו שהוריהם אינם קפדנים מספיק.

2. א. הרבה מהדברים המעציבים בחיי בני-אדם נגרמים, בחלקם, מחוסר מזל.
   ב. הצרות של בני-אדם הן תוצאה מהטעויות שלהם.

3. א. אחת הסיבות העיקריות שיש מלחמות בעולם נעוצה בכך שבני-אדם אינם מתעניינים מספיק בפוליטיקה.
   ב. תמיד תהיינה מלחמות בעולם לא חשוב עד כמה יתאמצו בני-אדם למנוע אותן.

4. א. במוקדם או במאוחר, בני-אדם זוכים לאותו כבוד המגיע להם בעולם הזה.
   ב. לדאבוננו, לעתים קרובות לא מכירים בערכו של אדם על אף כל מאמציו.

5. א. הדעה שמורים אינם הוגנים כלפי תלמידים היא שטות.
   ב. רוב התלמידים שאינם תופשים עד כמה ציוניהם מושפעים על-ידי גורמים מקריים.

6. א. בלי אותם מקרי מזל מיוחדים אדם לא יהיה מנהיג יעיל.
   ב. אנשים מוכשרים אשר אינם מצליחים להגיע לדרגת מנהיג, פשוט לא נצלו את אפשרויותיהם.

7. א. לא חשוב עד כמה שתשתדל, ישנם אנשים אשר פשוט לא מחבבים אותך.
   ב. אנשים אשר אינם מצליחים להתחבב על אחרים פשוט אינם מביניים איך להסתדר עם אחרים.

8. א. תורשה משחקת תפקיד עיקרי בקביעת אישיותו של האדם.
   ב. נסיונותיו וחוויותיו של האדם בחייו קובעים את אישיותו.

9. א. לעתים קרובות מצאתי שאם משהו צריך לקרות - זה יקרה.
   ב. מהסתמכות על הגורל אף פעם לא יצא לי כל כך טוב כמו מההחלטה לנקוט בפעולה מסויימת.

10. א. לגבי התלמיד המוכן היטב כמעט ולא קיים דבר כמו מבחן לא הוגן.
    ב. לעתים קרובות השאלות במבחן נוטות להיות כה בלתי קשורות לקורס עצמו עד שאין שום טעם להתכונן לבחינה.

11. א. להגיע להצלחה זה ענין של עבודה קשה; מזל משחק בכך תפקיד קטן או אפסי.
    ב. קבלת משרה טובה תלויה בעיקר בכך שתהיה במקום הנכון בזמן הנכון.

12. א. לאזרח הממוצע יכולה להיות השפעה על החלטות הממשלה.
    ב. עולמנו מונהג על ידי מספר קטן של אנשים שבשלטון, ואין ביכולתו של "האדם הקטן" לעשות הרבה בקשר לכך.

13. א. כשאני עורך לי תכניות, אני כמעט בטוח שאוכל לבצע אותן בהצלחה.
ב. אין זה תמיד מן החכמה לתכנן לסוגה ארוך מדי, כי הרבה דברים תלויים ממילא בגורל.

14. א. ישנם אנשים מטוימים שפשוט "אינם בני-אדם."
ב. יש מעט מהסוב בכל אדם.

15. א. כשאני רוצה להשיג משהו זה תלוי מעט מאד - או בכלל לא - במזל.
ב. לעתים קרובות כדאי פשוט להחליט מה לעשות על-פי "זריקת מטבע."

16. א. מי שיהיה ה"בוס" - זה תלוי לעתים קרובות במי ששק לו המזל והיה הראשון במקום הנכון.
ב. הבאת אנשים לידי כך שיעשו את הדבר הנכון, תלויה ביכולת; מזל כמעט ולא משחק בכך תפקיד.

17. א. לגבי בעיות בקנה-מידה עולמי, רובנו קרבנות לכוחות אשר אינבו מבינים אותם ואין לנו שליטה עליהם.
ב. על ידי השתתפות פעילה בתחומים פוליטיים וחברתיים, אנשים יכולים לכוון מאורעות עולמיים.

18. א. רוב האנשים אינם מכירים כמה חייהם מושפעים מהתרחשויות מקריות.
ב. אין באמת דבר כזה כמו "מזל."

19. א. אדם צריך תמיד להיות מוכן להודות בטעויותיו.
ב. בדרך כלל, זה הכי טוב כשאדם מחפה על שגיאותיו.

20. א. קשה לדעת אם אדם באמת מחבב אותם או לא.
ב. מספר החברים שיש לך תלוי במידת היותך אדם נחמד.

21. א. במרוצת הזמן, הדברים הרעים הקורים לנו "יאוזנו" ע"י הדברים הטובים.
ב. רוב האסונות באים כתוצאה מחוסר יכולת, בערות, עצלות - או שלשתן גם יחד.

22. א. במאמצים מספיקים אנו יכולים לחסל שחיתות פוליטית.
ב. קשה לאנשים לפקח במידה רבה על מעשיהם של פוליטיקאים כשהללו בשלטון.

23. א. לפעמים אינני יכול להבין איך מורים קובעים את הציונים שהם נותנים.
ב. יש קשר ישיר בין המאמצים שאני משקיע בלימודים לבין הציונים שאני מקבל.

24. א. מנהיג טוב מצפה מאנשיו שהם יחליטו מה לעשות.
ב. מנהיג טוב מבהיר לכל אחד מה תפקידו.

25. א. פעמים רבות אני מרגיש שיש לי שליטה מעטה על הדברים שקורים לי.
ב. אני פשוט לא יכול להאמין שהמקרה - או המזל - משחק תפקיד חשוב בחיי.

26. א. אנשים הינם בודדים מכיוון שאינם משתדלים להיות חברותיים.
ב. אין הרבה טעם לנסות למצוא חן בעיני אחרים; אם הם מחבבים אותך, הם מחבבים אותם - וזהו.

27. א. הספורט מודגש מדי בבתי-ספר תיכוניים.
ב. משחקי ספורט קבוצתיים הינם דרך מצויינת לפיתוח האופי.

28. א. מה שקורה לי בא בעקבות מעשי.
ב. לעתים אני מרגיש שאין לי שליטה מספקת על הכוון שבו חיי הולכים.

29. א. רוב הזמן אינני יכול להבין מדוע פוליטיקאים מתנהגים כפי שהם מתנהגים.
ב. במרוצת הזמן, האנשים הם האחראים לממשל רע - בין במישור ארצי בין במישור מקומי.

APPENDIX C
DEMOGRAPHIC AND PHYSICAL HEALTH QUESTIONNAIRE
English

1. Name _____

2. Age _____

3. Place of birth _____ 4. Year of arrival to Israel (if not born here) _____

5. Number of children _____ 6. Ages of children _____

7. Level of education: Elementary _____

   High school (partial) _____

   High school (full) _____

   College _____

   Graduate school _____

   Other (specify) _____

8. Number of married years _____

9. Are you working presently? yes/no 9a. Part/full time

10. Did you work before getting married?

11. Did you go to work after getting married?

12. Did you work before you husband died? yes/no

13. What is your present state of health?
    a. No special health problems _____
    b. Few health problems _____
    c. Many health problems _____

14. What was you state of health immediately following your husband's death?
    a. No special health problems _____
    b. Few health problems _____
    c. Many health problems _____

15. Since your husband's death, how frequently do you visit your doctor?
    a. Hardly at all _____
    b. From time to time _____
    c. Very frequently _____

16. Do you use tranquilizer? yes/no

17. If yes, how frequent?
    a. All the time _____
    b. From time to time _____
    c. Seldom _____
    d. Not at all _____

18. Did you use tranquilizers immediately following the death of your husband?
    yes/no

19. If yes, how frequent?
    a. All the time _____
    b. From time to time _____
    c. Seldom _____
    d. Not at all _____

20. Do you suffer from (mark your answer or answers)
    Headaches _____
    Insomnia _____
    Nightmares _____
    Weight problems (losing or gaining) _____
    Loss of apetite _____
    Weakness _____
    Tiredness _____
    Other (crying, nervousness etc.) _____

21. Any changes in your homekeeping activities?

Immediately after the loss	At present
_____ No changes	_____ No changes
_____ Less active than before	_____ Less active than before
_____ More active than before	_____ More active than before

22. Changes in social activities (relations with your family and you in-laws)

Immediately after the loss	At present
_____ No changes	_____ No changes
_____ Less than before	_____ Less than before
_____ More than before	_____ More than before

22a. Relations with friends

Immediately after the loss	At present
_____ No changes	_____ No changes
_____ Less than before	_____ Less than before
_____ More than before	_____ More than before

23. Who helped and supported you immediately after the loss?
    _____ Your family (mother, father, brothers, sisters etc.)
    _____ Your late husband's family
    _____ Neighbours
    _____ Friends
    _____ Social worker or rehabilitation counselor
    _____ Family doctor
    _____ Other (state, if you can)

24. Are you satisfied, in general, from yourself and the way you handle problems?
    _____ Very much
    _____ Satisfied
    _____ Partly satisfied
    _____ Not at all

25. Are you (please mark the one you agree most with)
    _____ Religious
    _____ Traditional
    _____ Secular

26. What are the greatest difficulties you encounter as a widow. Mark each sentence with the level of difficulty as you think it to be, from 0 to 4, when number 0 is the least difficult and number 4 is the most difficult.

_____ difficulties with children	0	1	2	3	4
_____ diffulties with your family	0	1	2	3	4
_____ diffulties with your in-laws	0	1	2	3	4
_____ financial difficulties	0	1	2	3	4
_____ difficulties in social contacts with old friends	0	1	2	3	4
_____ loneliness	0	1	2	3	4
_____ difficulties in establishing new social contacts	0	1	2	3	4
_____ health difficulties	0	1	2	3	4
_____ difficulties concerning your job (in case you have one)	0	1	2	3	4

27. Researcher's evaluation. Resolved/unresolved grief.

ש א ל ו ן ל א ל מ נ ה
HEBREW

1. שם פרטי_____

2. גיל_____

3. ארץ לידה_____ 4. שנת עליה לארץ (אם אינך יליד הארץ)_____

5. מספר הילדים_____ 6. גיל הילדים_____

7. השכלה: יסודית_____

מקצועית מלאה_____

תיכונית חלקית_____

תיכונית מלאה_____

על תיכונית_____

אחרת (פרסי)_____

8. כמה שנים היית בנשואים?_____

9. האם את עובדת עכשיו? כן/לא 9.(א) משרה מלאה/חלקית

10. האם עבדת לפני הנשואין? כן/לא

11. האם יצאת לעבודה אחרי שנישאתם? כן/לא

12. האם עבדת לפני מות בעלך? כן/לא

13. מהו מצב בריאותך הנוכחי?

א. אין בעיות בריאותיות מיוחדות_____

ב. מעט בעיות בריאותיות_____

ג. בעיות בריאותיות רבות_____

14. מה היה מצב בריאותך מיד לאחר מות בעלך?

א. לא היו בעיות בריאותיות מיוחדות_____

ב. היו מעט בעיות בריאותיות_____

ג. היו הרבה בעיות

בריאותיות_____

15. מאז מות בעלך, באיזו תכיפות את מבקרת אצל הרופא?

א. לעתים רחוקות מאד_____

ב. מדי פעם בפעם_____

ג. לעתים קרובות מאד_____

16. האם את משתמשת בתרופות הרגעה? כן/לא

17. אם כן, באיזו תכיפות?

א. באופן קבוע_____

ב. בתקופות מסוימות_____

ג. לעתים רחוקות_____

ד. בכלל לא_____

18. האם השתמשת בתרופות הרגעה מיד לאחר האסון? כן/לא

19. אם כן, באיזו תכיפות?

א. באופן קבוע_____

ב. בתקופות מסוימות_____

ג. לעתים רחוקות_____

ד. בכלל לא_____

20. האם את סובלת (סמני את תשובתך או תשובותייך)

כאבי ראש_____

נדודי שינה_____

חלומות רעים_____

בעיות במשקל (הורדת או הוספת)_____

חוסר תאבון_____

חולשה כללית_____

עייפות כללית_____

אחר (בוכה הרבה, עצבנית)_____

21. האם חלו שנויים בפעילויות הקשורות לבית ולמשק הבית

מיד לאחר האסון:	כיום:
____אין שינויים	____אין שינויים
____פחות פעילות מאשר מקודם	____פחות פעילות מאשר מקודם
____יותר פעילות מאשר מקודם	____יותר פעילות מאשר מקודם

22. שינויים בפעילות חברתית (קשרים עם המשפחה שלך, קשרים עם המשפחה של בעלך)

מיד לאחר האסון:	כיום:
____אין שינוי	____אין שינוי
____פחות קשרים מאשר קודם	____פחות קשרים מאשר קודם
____יותר קשרים מאשר קודם	____יותר קשרים מאשר קודם

22. א. קשרים עם חברים

מיד לאחר האסון:	כיום:
____לא היה שינוי	____אין שינוי
____פחות קשרים מאשר קודם	____פחות קשרים מאשר קודם
____יותר קשרים מאשר קודם	____יותר קשרים מאשר קודם

23. מיד לאחר האסון, מי סייע ועזר לך?

____קרובי משפחה שלך (אב, אם, אחים, אחיות)

____קרובי משפחת בעלך

____שכנים

____חברים

____עובדת השקום

____רופא המשפחה

____אחר

24. האם באופן כללי את מרוצה מעצמך ומהדרך בה את מתמודדת עם בעיות?

____מאד מרוצה

____מרוצה

____מרוצה במקצת

____מאד לא מרוצה

25. האם את

____דתית

____מסורתית

____חילונית

26. מהם הקשיים הגדולים ביותר בהם את נתקלת, כאלמנה? (סמני ליד כל משפט את מידת הקושי כפי הבראה בעינייך, כאשר מספר 1 הוא הפחות קשה ומספר 9 הוא בעל הקושי הגדול ביותר).

____קשיים עם הילדים	0 1 2 3 4
____קשיים עם המשפחה שלך	0 1 2 3 4
____קשיים בקשרים עם משפחת בעלך	0 1 2 3 4
____קשיים כספיים	0 1 2 3 4
____קשיים בקשרים עם חברים קודמים	0 1 2 3 4
____בדידות	0 1 2 3 4
____קשיים בקשרים עם חברים חדשים	0 1 2 3 4
____קשיי בריאות	0 1 2 3 4
____קשיים בעבודה מחוץ לבית	0 1 2 3 4

27. הערכה כללית להסתגלות

עבדה אבל/לא עבדה אבל

APPENDIX D

RESEARCHER'S QUESTIONNAIRE

English

Most widows go through various experiences during bereavement. Some of the experiences are with other people. I am interested in learning about those experiences with other people which are helpful to you, all the experiences you can remember which are helpful.

Please use this paper and write about experiences with other people that you can think of as helpful during bereavement.

Please try and give as many details as you possibly can as they will be of great help in the present study.

Thank you.

ש א ל ו ן ה ת נ ס ו י ו ת

HEBREW

רוב האלמנות עוברות התנסויות שונות בתקופת האבל. בחלקן, ההתנסויות הן עם אנשים אחרים. לעתים, אנשים רוצים ומנסים לעזור, ולעתים, זה לא כל כך עוזר.

אני מעוניינת באותן התנסויות עם אנשים אחרים אשר עזרו וסייעו לך, כל אותן התנסויות אשר היו לך לעזר.

אנא, השתמשי בדף שלפנייך וכתבי על כל ההתנסויות עם אנשים שאת זוכרת, ואשר היו לך לעזר בתקופת האבל.

אנא, השתדלי לפרט ככל האפשר, פרטים אלו יסייעו רבות במחקר זה.

תודה רבה.

RESEARCHER'S QUESTIONNAIRE

English

Most widows go through various experiences during bereavement. Some of the experiences are with other people. Sometimes people try and want to be helpful and sometimes it's not so helpful.

I am interested in learning about those experiences with other people which are not helpful.

Please use this paper and write about experiences with other people that you can think of which were not helpful to you during bereavement.

Please try and give as many details as you can possibly remember as they will be of great help in the present study.

Thank you.

ש א ל ו ן ה ת נ ס ו י ו ת

HEBREW

רוב האלמנות עוברות התנסויות שונות בתקופת האבל. בחלקן, ההתנסויות הן עם אנשים אחרים. אני מעוניינת באותן התנסויות עם אנשים אחרים אשר לא היו לך לעזר (כלומר, מה שעשו אנשים אחרים, לא עזר או סייע לך).

אנא, השתמש בדף שלפנייך וכתבי על כל ההתנסויות עם אנשים שאת זוכרת, ואשר היו לך לעזר בתקופת האבל.

אנא, השתדלי לפרט ככל האפשר, פרטים אלו יסייעו רבות במחקר זה.

תודה רבה.

APPENDIX E

INTRODUCTION LETTER TO THE PARTICIPANT

English

To the Participant,

I am collecting information for a study on widowhood. I would like to request to talk with you; I would like to ask you questions on the subject of widowhood and request your cooperation in completing questionnaires concerning the subject.

Participation is completely voluntary, so if for any reason you would rather not take part in this study feel free to say so. However, I would be glad to meet with you upon completion of the study and inform you of the results.

Your answers will be strictly confidential and will be used for evaluative purposes only.

Thank you for your participation.

Ruth Malkinson.

מכתב פנייה למרויינת
HEBREW

שלום לך,

במסגרת לימודי אני עורכת מחקר על אלמנות. אני פונה אלייך בבקשה לשוחח איתך. הייתי רוצה לשאול אותך שאלות בנושא האלמנות ולבקש ממך למלא כמה שאלונים בנושא זה.

נכונותך לענות על השאלות הינה לשקולך ותוכלי להחליט שאין ברצונך לעשות כן. עם זאת אשמח להפגש איתך עם סיום עבודתי זו ולשתף אותך במימצאים.

כל אינפורמציה שתמסר על ידך הינה סודית ותשמש אך ורק לצורכי הערכה.

אתקשר איתך בימים הקרובים לקביעת מועד לפגישה.

תודה על השתתפותך,

רות מלקינסון

APPENDIX F
CATEGORIES OF RESOLVED AND UNRESOLVED GRIEF
English

Expressions of anger, bitterness and criticism

1. No expression of anger, bitterness or criticism.

2. A minimal expression of anger, bitterness or criticism - a hint of the expression made by the widow following an unpleasant experience but which didn't persist.

3. A pronounced expression of anger, bitterness and criticism - anger, bitterness or criticism are persistant in most but not all the subjects the widow discusses.

4. A strongly pronounced expression of anger, bitterness and criticism - anger, bitterness or criticism are strongly and intensely expressed by the widows.

Levels of functioning and acceptance of the new reality which excludes the deceased spouse.

1. A high level of functioning and acceptance of new reality - there is an expression of self-acceptance as a single woman. The widow has formed new relations with friends, has good relations with her in-laws, goes out to work or studies and has a future orientation. She is aware of the difficulties but overcomes most of them.

2. A moderate functioning and acceptance of the new reality - the widow is functioning quite well, goes out to work or studies and maintains relations with old friends. Her relations with her in-laws are for the children's sake.

3. Some difficulties in functioning and acceptance of the new reality - the widow is functioning with some difficulties and what she does is for the children's sake rather than for her self. It could be better but the widow hasn't got the energy to change it. She goes out to work to keep herself busy. She has only few friends and her relations with her in-laws are not so close.

4. A lot of difficulties in functioning and acceptance of the new reality - the widow is functioning with many difficulties, including finances. She isn't working or studying, has lost interest in life, hasn't got any friends and has no contact with her in-laws.

עבוד אבל
HEBREW

בטויי כעס, מרירות ובקורת

1. בכלל לא בא לידי בטוי, לא מופיע, כלל לא מורגש.

2. מועט - בא לידי בטוי מסוים, בעיקר לגבי התנסויות בעבר. עוברת נימה מסוימת של בקורת או מרירות - כלפי עצמה או כלפי סביבתה.

3. בטוי בעוצמה ביונונית של כעס ובקורת - חוזר על עצמו, אך לא בכל הנושאים, גם לגבי התנסויות בעבר ובמידה מסוימת כיום, אם כי בהחלט קימת בקורת.

4. כעס ובקורת בעוצמה רבה - בולט ביותר, חוזר בכל הנושאים, קיימת מרירות רבה או בקורת כלפי עצמה, הסביבה או הבעל המת; תגובות אלו הינן ביחס לשחזור התנסויות מהעבר והן לגבי ההווה.

רמת תפקוד וקבלת המציאות החדשה שאינה כוללת את הבעל המת.

1. בהחלט מתמודדת ומקבלת עצמה בתפקידה הנוכחי, עם ולמרות הקשיים. מקדמת עצמה בעבודה או בלימודים - "החיים הם שלי." יצרה קשרים חברתיים חדשים, ומקימת קשרים עם משפחת הבעל.

2. מתמודדת - מתפקדת, פועלת, עובדת או לומדת. מציינת קשיים, אך חושבת שבמצבה שלה יכול היה להיות יותר גרוע. שומרת על קשרים חברתיים בעיקר עם חברים קודמים, וכן משפחת הבעל, גם אם רק למען הילדים.

3. מתקשה במעט להתמודד - את שעושה - עושה לא למען עצמה אלא למען הילדים. שומרת על שגרה, אולי יכול היה להיות אחרת אך אין כח לשנות. עם זאת לא הפסיקה לפעול - מתפקדת בבית, עובדת או לומדת באופן חלקי - "בעיקר כדי להעביר את הזמן." מציינת את הקשיים הרבים. אין הרבה קשרים חברתיים, מעט קשרים אם בכלל, עם משפחת הבעל.

4. מתקשה מאד לתפקד ולהתמודד עם המציאות החדשה - "החיים לא שוים יותר," מגלה חוסר עניין בנעשה סביבה, לא עובדת ולא לומדת. במידה ויוצאת לעבודה אינה מרוצה ממנה ועושה זאת כדי לברוח מהבית. החיים בשבילה נגמרו; לא מתארגנת, אין קשרים חברתיים כלל, כולל משפחת הבעל.

APPENDIX G
CATEGORIES OF REPORTED EXPERIENCES
English

Intensity of reported helpful experiences

1. A mild helpful experience - a reported experience which neither helps nor hurts. The widow understands that people want to help but her report reveals only a minimal appreciation to the support offered to her.

2. A helpful experience - a reported experience which was helpful-widow accepts that people want to help when a stressful event occurs and she expresses some appreciation for the support she receives.

3. A very helpful experience - a reported experience that helps and encourages the widow and induces a feeling of closeness. The widow appreciates the support and feels she couldn't have managed without it.

4. A most helpful experience - an experience which is most appreciated and valued. It is a meaningful experience followed by a closer relationship with the helper. She is made to feel better and stronger and without this help and support she couldn't have managed.

Intensity of reported unhelpful experiences

1. A mildy unhelpful experience - the experience is unpleasant but the widow understands that sometimes what people do or say is intended to help even if in practice it didn't. This experience didn't affect the relationship or her decision to ask for help in the future.

2. An unhelpful experience - an unpleasant experience with others which hurts the widow. She becomes more cautious as a result of her experience would ask for help in future if there would be no other choice.

3. A very unhelpful experience - a hurtful experience which affects her relationship with others, even breaking them off for a period of time but resuming them later. She is critical of the way people behaved towards her. She becomes more selective in her relationship as a result of the experience and would consider help in the future more carefully.

4. A most unhelpful experience - a painful experience with others which make her feel humiliated and affects her relationship to the point of breaking them off without resuming them. She is most critical about the way people "help."

דוחי התנסויות עזרות
HEBREW

עוצמה

1. התנסות עזרת במידה מועטה מאד - התנסות שלא הוסיפה ולא גרעה, אפשר היה להסתדר בלי זה. האלמנה מבינה שבעצם אנשים רוצים לעזור ומקבלת את עזרתם. ישנה הערכה מעטה לעזרה ולסיוע.

2. עזר במקצת - עזרה שניתנה והתקבלה ע"י האלמנה כמובנת - במצב כזה צריך לעזור ומובן שעוזרים. ישנה מידת הערכה מסוימת לעזרה ולסיוע.

3. התנסות עוזרת - התנסות שעזרה, חזקה ועודדה, הביאה להתקרבות מסוימת. האלמנה העריכה את העזרה וחושבת שלא היתה מסתדרת בלעדיה.

4. התנסות עוזרת ביותר - האלמנה העריכה ביותר את העזרה והסיוע. זוהי התנסות שקרבה והדקה את הקשרים, נתנה הרגשה טובה, חזקה ועודדה ביותר. בהחלט לא היתה מסתדרת ללא הסיוע שניתן לה.

דוחי התנסויות לא עוזרות

עוצמה.

1. התנסות לא עוזרת במידה מועטה - ישנו דוח על ההתנסויות הלא עוזרות בתדירות ובעוצמה נמוכות. האלמנה עברה לסדר היום, מבינה שאנשים עשו או אמרו ללא כוונה, דברים שהיו לא נעימים, אך בעצם לא התכוונו לכך. לא תמיד ידעו שהיא אלמנה. היא סלחנית, אין נימה של בקורת, התנסויות אלו לא ישפיעו על בקשת עזרה בעתיד.

2. התנסות לא עוזרת במידה בינונית - זה לא היה נעים, זה הותיר משקע, אך לא גרם להתרפק יחסים או נתוקם. ישנה נימה מועטה של בקורת, תבקש עזרה כשלא תהיה ברירה.

3. התנסות לא עוזרת - התנסות שהותירה משקע, החריפה יחסים אך לא גרמה לנתוקם לגמרי, או שהיה נתוק אך קשרים חודשו. האלמנה תהיה סלקטיבית לגבי עזרה בעתיד - הן ממי שתבקש והן מה שתבקש. בקורתית לגבי היחס והצורה שבה נעשו דברים.

4. התנסות מאד לא עוזרת - התנסות שפגעה וגרמה להרגשה קשה ולעלבון רב. התנסות מאד לא עוזרת - התנסות שפגעה וגרמה להרגשה קשה ולעלבון רב. התנסות שבעקבותיה היתה התדרדרות במערכת היחסים בין האנשים ובינה. התנסות שגרמה לאלמנה לא לבקש עזרה נוספת. היא מאד בקורתית על היחס ועל הצורה בה נעשו הדברים.

BIOGRAPHICAL SKETCH

I was born in Israel in 1938.

I graduated as a Bachelor of Social Work in 1962 from the Hebrew University, Jerusalem, and worked as a probation officer and school social worker. Between 1970-1974, I studied school counseling and lectured at the School of Social Work (Tel Aviv University). In 1975 I graduated as M.A. (cum laude) in school counseling from Tel Aviv University. Since 1976 I am registered as a Ph.D. student, at the University of Florida, Gainesville.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Theodore Landsman, Chairperson
Professor of Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Franz R. Epting
Professor of Psychology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Paul G. Schauble
Professor of Psychology

This dissertation was submitted to the Graduate Faculty of the Department of Counselor Education in the College of Education and to the Graduate Council, and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

August 1983

Dean for Graduate Studies and Research